



MINISTERUL AFACERILOR EXTERNE

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2861 R/AG/296 9306 R/AG/82  
2398 R/AG/92 2575 R/AG/134 4023 R/AG/285 6262 R/AG/185

**Domnule președinte,**

Mă adresez dumneavoastră în legătură cu reuniunea Comitetului Miniștrilor în format Drepturile Omului (CM-DH sau Comitetul) nr. 1468, dedicată supravegherii executării hotărârilor Curții Europene a Drepturilor Omului (CEDO sau Curtea), care a avut loc la Strasbourg între **5 și 7 iunie 2023**.

Pe agenda acestei reuniuni s-au aflat trei **cauze/grupuri de cauze** îndreptate împotriva României, și anume **Brăgădoreanu împotriva României și Rezmiveș și alții împotriva României**, respectiv **Centrul de Resurse Juridice în numele lui Valentin Câmpeanu împotriva României și grupul Cristian Teodorescu și cauzele Parascineți, N., R.D. și I.M.D. împotriva României** (acesta din urmă, cu dezbateri). Menționăm de asemenea că a fost adoptată **rezoluția finală de închidere a supravegherii în cauza Kövesi împotriva României**.

**1. Cauzele Centrul de Resurse Juridice în numele lui Valentin Câmpeanu împotriva României și N. (nr. 2) împotriva României**

În ceea ce privește **cauzele Centrul de Resurse Juridice în numele lui Valentin Câmpeanu împotriva României și N (nr. 2) împotriva României** (deficiențe ale sistemului de protecție juridică a adulților cu dizabilități intelectuale și cu afecțiuni psihice, în special limitările drastice aduse capacității acestor persoane de a-și exercita drepturile și indisponibilitatea unor soluții adecvate pentru situația adulților vulnerabili care nu au nicio rudă capabilă sau dispusă să

**Domnului Nicolae Ionel Ciucă**  
**Președinte**  
**Senatul României**

acționeze în numele lor și, în mod specific în cauza *CRJ în numele lui Valentin Câmpeanu*, alte deficiențe grave în ceea ce privește asistența socială și medicală acordată unui tânăr orfan cu dizabilități intelectuale, absența unei anchete efective privind circumstanțele decesului său și lipsa unor căi de atac efective), a fost adoptată, fără dezbateri, o decizie.

Decizia CM ia act cu satisfacție de faptul că, ulterior deciziei Curții Constituționale din iulie 2020 prin care s-a declarat neconstituțional sistemul de tutelă în vigoare la acel moment, Parlamentul a adoptat o lege<sup>1</sup> care introduce un nou sistem gradual de protecție juridică pentru adulții vulnerabili.

În ceea ce privește **măsurile individuale**, decizia solicită autorităților să confirme rapid plata satisfacției echitabile acordate în cauza *N. (nr. 2)*<sup>2</sup> pentru prejudiciul moral și invită autoritățile să indice dacă reclamantul N. s-a prevalat de posibilitatea oferită de noua legislație de a solicita instanțelor de judecată să reevalueze situația sa.

În ceea ce privește **măsurile generale**, prin decizie se solicită autorităților să monitorizeze îndeaproape punerea în aplicare a noului sistem de sprijin și de protecție juridică, în special reevaluarea în curs a situației celor care au fost anterior plasați sub tutelă și să ia toate măsurile necesare pentru a se asigura că noua legislație este aplicată în mod adecvat și eficient.

Autoritățile sunt îndemnate cu fermitate să își dubleze eforturile pentru a promulga, fără întârziere, soluții conforme cu prevederile Convenției pentru situația celor care nu au nicio rudă capabilă sau dispusă să preia sarcinile de sprijin sau de reprezentare în cadrul noului sistem, subliniind că astfel de soluții sunt esențiale pentru a asigura accesul efectiv la justiție pentru acest grup de persoane deosebit de vulnerabile.

Este subliniat, în plus, imperativul de a asigura respectarea drepturilor omului în ceea ce privește tratamentul persoanelor cu handicap care sunt încă plasate în medii instituționalizate și închise, precum și responsabilitatea pentru

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<sup>1</sup> Este vorba de Legea nr. 140/2022 privind unele măsuri de ocrotire pentru persoanele cu dizabilități intelectuale și psihosociale și modificarea și completarea unor acte normative.

<sup>2</sup> Acest aspect a fost deja rezolvat, fiind transmisă către Comitet dovada efectuării plății despăgubirilor acordate de Curte, plata fiind efectuată în termenul stipulat de hotărârea CEDO.

acest tratament, în așteptarea finalizării procesului în curs de tranziție către o viață independentă, bazată pe comunitate.

Este reamintit că România a introdus în legislație dispoziții care acordă organizațiilor societății civile *locus standi* în procedurile care implică drepturile și interesele legitime ale persoanelor cu handicap, îndemnând autoritățile să se asigure că protecția pe care o oferă sunt practice și eficiente.

**Autoritățile sunt invitate să furnizeze informații relevante până cel târziu la 30 septembrie 2023 și să informeze în mod corespunzător Comitetul. Următoarea examinare a cauzei va avea loc cel târziu la reuniunea CM din iunie 2024.**

**2. Grupul de cauze Parascineti, grupul Cristian Teodorescu și cauzele N., R.D. și I.M.D împotriva României.**

Vă supunem atenției și **grupul de cauze Parascineti, grupul Cristian Teodorescu și cauzele N., R.D. și I.M.D.** (probleme structurale legate de supraaglomerarea și de condițiile de viață, tratamentul și îngrijirea inadecvate pentru pacienții din instituțiile psihiatrice din România, privarea ilegală sau arbitrară de libertate a pacienților plasați involuntar în astfel de instituții și deficiențe în procedurile relevante și în garanțiile care însoțesc plasamentele involuntare și tratamentul psihiatric acordat acestor pacienți; aspecte referitoare la statul de drept și preocupări umanitare în ceea ce privește persoanele care aparțin unui grup deosebit de vulnerabil) Secretariatul a pregătit un proiect de decizie, care a fost adoptată în urma dezbaterii, fără a suferi modificări.

În ceea ce privește **măsurile individuale**, decizia reamintește că toți reclamanții din cazurile **Parascineti, Cristian Teodorescu și Atudorei** își redobândiseră libertatea până la momentul în care Curtea a pronunțat hotărârile, nemaifiind necesare măsuri suplimentare în situația lor – supravegherea urmând a fi închisă.

În ceea ce privește situația reclamantului N., este reiterat apelul către autorități de a continua să monitorizeze situația pentru a se asigura că măsurile care au permis externarea acestuia din spitalul de psihiatrie în comunitate rămân în vigoare atâta timp cât situația o impune. De asemenea, se ia act de faptul că reclamanții R.D. și I.M.D. au fost eliberați din detenția psihiatrică cu condiția să urmeze un tratament psihiatric ambulatoriu.

În ceea ce privește **măsurile generale**, sunt amintite deciziile CM anterioare și Rezoluția interimară CM/ResDH(2022)49 adoptată în cazul *N.*, precum și preocupările sporite ale CM cu privire la persistența deficiențelor structurale și la eșecul prelungit al autorităților române de a lua măsuri pentru a pune capăt și a garanta nerepetarea încălcărilor.

Se ia act de constatările din Raportul Avocatului Poporului din România privind respectarea drepturilor omului în unitățile de psihiatrie din România, precum și de observațiile recente ale societății civile care atestă încă o dată necesitatea urgentă de a lua măsuri. De asemenea, se ia act cu interes de recentele inițiative promițătoare conduse de părțile interesate din sectorul public și de societatea civilă, orientate către definirea și avansarea de soluții, dar este deplânsă lipsa oricărui indiciu că autoritățile sunt acum angajate în elaborarea unui răspuns strategic, cuprinzător și coordonat la hotărârile Curții, inclusiv atunci când vine vorba de asigurarea unor resurse financiare pentru a susține acțiunile necesare.

Autoritățile sunt îndemnate să dea dovadă de cea mai fermă determinare și angajament, la un nivel politic înalt, oferind impuls, direcție și coordonare acțiunilor necesare pentru punerea în aplicare a hotărârilor.

**Autoritățile sunt de asemenea îndemnate cu fermitate să prezinte CM, până cel târziu la 30 septembrie 2023, o foaie de parcurs clară și precisă, cu un calendar cu termene rapide, pentru finalizarea și adoptarea la cel mai înalt nivel al guvernului a unui plan de acțiune cuprinzător care să abordeze pe deplin și în mod durabil deficiențele structurale evidențiate de aceste hotărâri.**

Decizia atrage atenția asupra analizei Secretariatului prezentată în documentul H/Exec(2023)5 și asupra observațiilor generale finale privind acțiunile necesare și prioritățile urgente pentru executarea hotărârilor Curții.

Decizia subliniază aspectul umanitar al încălcărilor constatate și necesitatea urgentă de a depăși impasul în soluționarea acestora și de a avansa procesul de executare, invitând autoritățile statelor membre ale Consiliului Europei să ridice problema punerii în aplicare a acestor hotărâri în contactele lor cu autoritățile române.

**Reexaminarea acestor cazuri va fi reluată în cadrul reuniunii din martie 2024** și, în absența unor progrese semnificative în vederea finalizării și adoptării planului de acțiune necesar, Secretariatul va pregăti un **proiect de rezoluție interimară**<sup>3</sup>.

Vă supunem atenției și elementele relevante din **Evaluarea Secretariatului cu privire la măsurile generale în grupul de cauze Parascineți, grupul Cristian Teodorescu și cauzele N., R.D. și I.M.D.** (documentul H/Exec(2023)5). Documentul detaliază problemele, identificate de Curte și de Comitetul Miniștrilor, și care încă nu au fost remediate. Anexat acestei scrisori regăsiți atât Evaluarea Secretariatului integrală, cât și o traducere neoficială a acesteia.

Vă adresez astfel rugămintea de a avea în vedere, în eventualele propuneri și proiecte legislative care vor fi dezbătute la nivelul Senatului, de aspectele reținute de Comitetul Miniștrilor ca necesare pentru executarea acestor.

Primiți, vă rog, domnule președinte, asigurarea deplinei mele considerații.

Luminita Odobescu /

Anexe:

Anexa 1 – Note Secretariat *Centrul de Resurse Juridice în numele lui Valentin Câmpeanu împotriva României*

Anexa 2 – Decizia *Centrul de Resurse Juridice în numele lui Valentin Câmpeanu împotriva României*

Anexa 3 – Note Secretariat *grupul Cristian Teodorescu și cauzele Parascineți, N., R.D. și I.M.D. împotriva României*

Anexa 4 – Decizia *grupul Cristian Teodorescu și cauzele Parascineți, N., R.D. și I.M.D. împotriva României*

Anexa 5 – Evaluarea Secretariatului cu privire la măsurile generale în cauzele referitoare la sănătatea mintală (EN)

Anexa 6 – Evaluarea Secretariatului cu privire la măsurile generale în cauzele referitoare la sănătatea mintală (RO)

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<sup>3</sup> Rezoluțiile interimare sunt instrumentele prin care CM-DH critică statele care nu vor sau nu pot să execute hotărârile CEDO.

**1468<sup>th</sup> meeting, 5-7 June 2023 (DH)**

Human rights

**H46-22 Centre for Legal Resources on behalf of Valentin Câmpeanu and N. (No. 2) v. Romania (Applications Nos. 47848/08 and 38048/18)**

Supervision of the execution of the European Court's judgments

Reference documents

DH-DD(2023)354-rev, DH-DD(2022)542, CM/Del/Dec(2019)1348/H46-20

**Action – Item proposed without debate**

To adopt the draft decisions below.

Application	Case	Judgment of	Final on	Indicator for the classification
47848/08	CENTRE FOR LEGAL RESOURCES ON BEHALF OF VALENTIN CÂMPEANU	17/07/2014	Grand Chamber	Complex problem
38048/18	N. (No. 2)	16/11/2021	16/02/2022	Complex problem

**Cases description**

These cases concern deficiencies in the legal protection system for adults with intellectual disabilities or with mental health conditions (substantive violation of Article 2 in *Centre for Legal Resources on behalf of Valentin Câmpeanu*; violations of Article 8 in *N. (No. 2)*).

In the first judgment, the European Court found that the solutions provided for by the law concerning vulnerable adults with no relative able or willing to take over representation duties do not guarantee that those appointed as representatives will act independently and effectively on behalf of the protected persons. In the second judgment, it found that the only form of protection then available (guardianship) entailed legal incapacitation and made the protected persons dependent on their legal guardians, to whom the courts transferred the exercise of the former's rights. The domestic law thus did not allow for a proportionate, tailor-made response to the person's circumstances, whose actual needs and wishes could not be factored into the decision-making process, including when it came to replacing a legal guardian.

The case of *Centre for Legal Resources on behalf of Valentin Câmpeanu* further concerns other serious shortcomings in the social and medical care afforded to a young man of Roma<sup>2</sup> origin, orphaned, HIV-positive and with "severe intellectual disability" before his death at the neuropsychiatric hospital of Poiana Mare in 2004 (substantive violation of Article 2); the ineffectiveness of the investigation and the court proceedings into his death (procedural violation of Article 2); and the lack of a domestic legal framework suited to the specific needs of people with disabilities and allowing for the examination of allegations concerning violations of their Convention rights by an independent authority (violation of Article 13 taken together with Article 2).

<sup>1</sup> This document has been classified restricted until examination by the Committee of Ministers.

<sup>2</sup> The terms "Roma and Travellers" are being used at the Council of Europe to encompass the wide diversity of the groups covered by the work of the Council of Europe in this field: on the one hand a) Roma, Sinti/Manush, Calé, Kaale, Romanichals, Boyash/Rudari; b) Balkan Egyptians (Egyptians and Ashkali); c) Eastern groups (Dom, Lom and Abdal); and, on the other hand, groups such as Travellers, Yenish, and the populations designated under the administrative term "*Gens du voyage*", as well as persons who identify themselves as Gypsies.

## Status of execution

The Committee of Ministers' last examination of the case of *Centre for Legal Resources on behalf of Valentin Câmpeanu* took place in June 2019 (1348<sup>th</sup> meeting (DH)).

This is the Committee's first examination of *N. (No. 2)*.

The authorities provided updated information on general measures, relevant also to the applicant's situation in *N. (No. 2)*, on 16 May 2022 (DH-DD(2022)542) and on 22 March 2023 (DH-DD(2023)354-rev), summarised below.

### Individual measures:

In *Centre for Legal Resources on behalf of Valentin Câmpeanu*, the Committee concluded with regret that no further measure was possible with respect to the situation of the late Mr Câmpeanu.

In *N. (No. 2)*, the authorities indicated that they would submit shortly confirmation of the payment of the just satisfaction awarded by the Court for non-pecuniary damage and for costs and expenses.

As regards the other measures required to provide *restitutio in integrum* to the applicant, the violations stem from his legal incapacitation, placement under guardianship and subsequent change of legal guardian, under a legal framework which did not meet the requirements of Article 8. This framework was reformed in 2022. The applicant has now the possibility to request the domestic courts to re-assess his situation and to lift his guardianship or to replace it with one of the new forms of protection introduced by the new legislation (see under "general measures").

### General measures:

#### 1) *Measures common to both cases: reform of the legal protection system for vulnerable adults*

In the relevant judgment, the European Court underlined the need to ensure that persons in a situation comparable to that of Mr Câmpeanu benefit from independent and effective legal representation. When the judgment came under its supervision, the Committee emphasised that the provision of such legal protection must comply with international standards requiring that measures relating to the exercise of legal capacity respect the rights, will and preferences of the persons concerned, and be proportionate and tailored to their circumstances (see CM/Notes/1265/H46-21). This was prompted by concerns about guardianship which have more recently led the Court to conclude that its legal regime breached Article 8 (*N. (No. 2)*).

In response to the first judgment, the authorities took preliminary steps to enact legislation to allow independent representatives to be designated for vulnerable adults who had no relative able or willing to act as guardians.<sup>3</sup> They planned to reform guardianship once the above steps had been completed.

The authorities changed their approach, however, following a July 2020 ruling of the Constitutional Court finding that the guardianship system infringed human dignity and was therefore unconstitutional.<sup>4</sup>

In consequence of that ruling, Parliament enacted legislation introducing a new system of support and legal protection for vulnerable adults, which came into force on 18 August 2022.

The new system provides for three measures, which can be gradually applied if the persons concerned have not made arrangements in advance. The first measure maintains fully the individual's legal capacity and provides support to decision-making; it is applied by a public notary, at the request of the person wishing to benefit from it. The other two involve limitations on legal capacity, whose content is to be modulated by the courts according to the degree of autonomy and the specific needs of the person concerned.

<sup>3</sup> They put forward draft legislative proposals which the Committee assessed in June 2019, finding that they raised several problems (see CM/Notes/1348/H46-20 for details).

<sup>4</sup> In more detail, the Constitutional Court found that system to breach the constitutional requirements that any protection measure must be proportionate to the degree of incapacity, tailored to the person's circumstances, applied for the shortest time and subject to periodic review, and that it takes into account the will and preferences of the protected person.

The measures can initially be applied for periods of up to two, three or five years respectively,<sup>5</sup> and can be renewed. The protected person has the possibility to request the public notary or the courts to lift the measure applied, at any time. In all relevant court proceedings, legal assistance is mandatory and will be provided *ex officio* if the person concerned does not have a chosen counsel. The courts must hear the person, unless he/she is unable to express his/her wishes or a medical report attests that a hearing would be detrimental to his/her health.

The new law requires the courts to re-assess the situation of those placed under guardianship under the previous legislation and to lift that measure or replace it with one of the new measures available. This process must be completed within three years from the entry into force of the law (i.e. by 18 August 2025). The Supreme Judicial Council and the National Institute for the Judiciary must ensure that training is provided to judges and prosecutors on the new forms of protection, over the period 2022-2024.

The new law did not implement solutions to the situation of those persons who, like Valentin Câmpeanu, have no relative able or willing to take over support or representation duties. It specifies that this will be settled through another piece of legislation, which will set out the conditions in which a personal representative can be appointed to assist or to represent them.

## 2) Measures specific to Centre for Legal Resources on behalf of Valentin Câmpeanu

### a. Measures to strengthen the safeguards in decision-making related to placements in public care

One of the aspects which led the Court to conclude that the authorities had breached Mr Câmpeanu's right to life were the decisions taken by the social and medical services as regards his placement once he had attained majority. Those decisions had been based on the willingness of the facilities to receive him and not on their ability to provide appropriate medical treatment, without adequate diagnosis and monitoring and in disregard of his health condition and his most basic medical needs.

At previous examinations, it was observed that such decisions remained within the sole purview of the social services and of the host care facilities and that the Ombudsperson and civil society had continued to find similar dysfunctions in relation to placements in residential care facilities and to transfers of residents between such facilities or to psychiatric establishments, even though these are not suitable facilities to care for people with intellectual disabilities (for details see CM/Notes/1302/H46-23).

The Committee concluded that the authorities had to take measures to guarantee non-repetition of the violation. It indicated that an *ex officio* periodic review of a judicial character could be an appropriate means to achieve this, considering the specific situation of these people and the difficulties they would have in themselves bringing proceedings related to their placement.<sup>6</sup>

At the last examination, in the absence of any information from the authorities on this issue, the Committee called on them to identify, in close cooperation with the Secretariat, appropriate solutions.

This issue was amongst those discussed during exchanges between the Department for the Execution of Judgments and the relevant authorities held in Bucharest in June 2022. The authorities indicated they would provide further context to the Committee, as they did not readily see a need to subject decisions relating to such placements to an independent review of judicial character.

The authorities have not addressed this matter in their subsequent submissions. They referred instead to a process of de-institutionalisation of people with disabilities placed in residential social care facilities, and to a law enacted in January 2023 to accelerate it. Based on the targets set in this law, it appears that this process will not be completed until the 2030s.

<sup>5</sup> Exceptionally, the most restrictive one (special guardianship) can be initially applied for up to 15 years, where "the deterioration of the mental capacities of the protected person is permanent".

<sup>6</sup> The other issue these findings raise, which concerns the failure of this hospital to apply the procedure and safeguards for involuntary psychiatric placement when Mr Câmpeanu was transferred there, is examined in the group of cases *Cristian Teodorescu v. Romania*.

b. Measures to guarantee effective criminal investigations into acts and omissions concerning vulnerable persons who are placed in institutions, which could fall within the scope of Article 2 or 3

The violation stemmed from the authorities' failure to conduct immediately a medico-legal autopsy, to establish whether Mr Câmpeanu's death could have been the result of an inadequate therapeutic approach; and from the superficial character of the investigation carried out, which had failed to consider the above factor and the objective situation prevailing at the Poiana Mare hospital at the relevant time.

At the last examination, it was noted that earlier measures had not sufficed to guarantee that social care facilities inform the investigating authorities of the deaths of their residents, to ensure that a medico-legal autopsy, mandatory in such cases, is performed. The Committee requested the authorities to provide information on further measures taken or envisaged to address this.

The authorities have not provided any new information on this aspect.

As regards criminal investigations, the Committee, which had welcomed the measures adopted by the General Prosecutor's Office ("GPO") in 2016 and 2017 to strengthen their effectiveness,<sup>7</sup> requested the authorities to submit relevant data and information demonstrating their practical impact.

In their March 2023 submissions, the authorities provided some of the data requested, for the period 2017 (second semester) to 2022. This shows that the great majority of the investigations (2,069, of which 1,093 concerned suspicious deaths) had been discontinued; 30 such decisions had been quashed by the higher prosecutor; and 33 cases had been sent to trial or settled through plea agreements.

The authorities also indicated that the GPO and the NGO Centre for Legal Resources are implementing together a project (AdaptJust) with EEA and Norway Grants funding, which is aimed at supporting the execution of this and of other judgments of the Court finding violations of rights of vulnerable persons, including through capacity building for relevant professionals.<sup>8</sup>

The authorities moreover recalled that Romania established in 2016 a National Council responsible for monitoring the implementation of the UN Convention on the Rights of Persons with Disabilities (the "NMC"). Its main function is to secure respect for the rights of people placed in residential social care facilities and psychiatric establishments. In this context, it must refer to the judicial bodies in case of evidence of criminal offences committed against institutionalised persons and ensure that any deaths which have occurred in these facilities have been reported to the latter. It can also challenge decisions to discontinue such investigations.

In their March 2023 submissions, the authorities provided information from the NMC indicating that it was about to finalise its internal procedure for reporting suspected criminal offences to the prosecution service. On its part, this service has started to notify decisions to discontinue relevant investigations to the NMC, to enable it to challenge them. In 2022, the NMC received such notifications in 48 cases (of a total of 415) and confirmed that the decisions had been also communicated to the injured parties or their representatives. It took no further action, in the absence of requests from the latter to challenge the decisions.

c. Measures to ensure accessible and effective legal remedies

The European Court found that (i) the domestic legal framework was ill-suited to address the specific needs of people with mental disabilities, notably regarding the absence of any practical possibility for them to have access to any available remedy and that (ii) the legal avenues put forward by the authorities (complaint to the Ombudsperson or action in compensation for medical negligence) were either insufficient or lacking in effectiveness, in view of their limited impact and the lack of procedural safeguards they afforded.

The authorities indicated that the question of access to remedies would be settled through the measures aimed at ensuring that those concerned can benefit from independent and effective legal representation. Meanwhile, a law enacted in 2016 to implement some of Romania's obligations under the UN Convention on the Rights of Persons with Disabilities (CRPD) granted NGOs *locus standi* in proceedings involving rights and legitimate interests of people with disabilities before courts and other independent bodies.

<sup>7</sup> These are summarised in the Notes on the Agenda of the Committee's 1265th meeting (September 2016) (DH), 1280th meeting (March 2017) (DH) and 1302nd meeting (December 2017) (DH).

<sup>8</sup> Judges, prosecutors, psychiatrists, psychologists, forensic doctors, lawyers, social care workers. The project includes training of trainers in 2022, followed by twenty interdisciplinary training sessions across the country in 2022-2023; 261 participants, including 57 prosecutors, received training during the first 12 sessions.

The Committee considered, including at its last examination, that the authorities had moreover to ensure that adequate procedures are in place allowing persons placed in residential social care facilities and psychiatric establishments to bring complaints related to their health and treatment before the courts or other independent bodies.

The authorities have not provided any new information on this aspect.

Latest submissions from civil society (Rule 9(2))

On 21 April 2023, the Committee received a new submission from the Centre for Legal Resources ("CLR") (see DH-DD(2023)546 for full details).

The CLR positively notes the recent reform of the legal protection system but calls for swift solutions also for those who have no relative to take over support or representation duties under the new law.

The NGO is moreover concerned that the implementation of this law is hindered by some obstacles, and calls for remedial action. One of the obstacles is the lack of training for judges, as the National Institute for the Judiciary has not yet included relevant capacity building in its curricula, and only a few judges have attended the training sessions organised by the CLR so far. Other obstacles are linked to the lack of sufficient experts in the public health care system to conduct the medical and psychological evaluations which are mandatory in the proceedings under the new law, and the fact that the costs of such evaluations by private practitioners are not covered by the national health insurance fund. The CLR reports that this is causing delays in re-assessing the situation of those previously placed under guardianship (about 90,000 people, according to the data provided by the Ministry of Justice).

The CLR further reports that during the visits it has carried out in institutions for people with disabilities it has continued to find dysfunctions in relation to decisions on placements and on transfers of residents and situations raising suspicions of neglect. The legal mechanisms in place to ensure accountability are either not functional or otherwise hampered. On the one hand, the NMC has not yet referred any case involving suspected breaches of rights of institutionalised people to the investigating authorities. On the other hand, the CLR's practical possibility to act on behalf of those concerned has been greatly restricted, as the Ministry of Labour and Social Solidarity has recently terminated the protocol enabling this NGO to carry out monitoring visits in relevant institutions under this Ministry.

In the longer term, the CLR considers that the authorities can address the deficiencies revealed by the judgments in a lasting way by completing the de-institutionalisation process they have started. Meanwhile, it calls for measures to improve the safeguards and to guarantee access to justice for people with disabilities or with mental health conditions placed in institutions, including by strengthening the NMC and improving its functioning; allowing unhindered access of civil society organisations to these people; establishing clear and accessible complaints mechanisms; and improving the capacity of officials in the justice system to handle cases involving rights of people with disabilities.

**Analysis by the Secretariat**

Individual measures:

The authorities could be requested to rapidly confirm the payment of the just satisfaction in *N. (No. 2)*. They could be also invited to indicate whether the applicant has brought proceedings with a view to have his guardianship lifted or replaced with one of the new forms of legal protection available in domestic law and if so, what is the status of those proceedings.

General measures:

1) *Reform of the legal protection system for vulnerable adults*

The recent reform of this system, which has provided an adequate response to the Committee's relevant calls in the *Valentin Câmpeanu* judgment and to the European Court's findings and indications in *N. (No. 2)*, is a key development and should therefore be welcomed.

It remains, however, for the authorities to make sure that the new legislation is adequately and effectively implemented, in particular when it comes to re-assessing the situation of those who had been placed under guardianship under the previous system. This is a crucial component of the action required to execute the judgment in *N. (No. 2)*, as the European Court found the previous system to breach Article 8 and the authorities have thus an obligation, under Article 46 of the Convention, to put an end to similar ongoing violations.

The authorities should follow-up closely the situation and take every necessary measure to this end, including by addressing the concerns civil society has raised about difficulties and obstacles they have identified in implementing the new legislation.

It remains moreover for the authorities to pursue their reform action and implement the measures still required to fulfil their Article 46 obligation in the first judgment, by ensuring that people in a situation comparable to that of Valentin Câmpeanu can benefit from independent and effective support and representation, in one of the protection forms available under the new legislation.

In the judgment, the Court found inadequate the existing provisions which allow designating as representative a local public authority or private-law entity that provides care for the person protected when the latter has no relative able or willing to take over representation duties. Solutions are therefore required which ensure that every person in such a situation has a representative; that there is no risk of conflict between the interests of the appointed representative and those of the protected person; and that the former will effectively act in the interest of the latter.

Given the long time that has passed since that judgment came under the Committee's supervision, the authorities could be strongly urged to redouble their efforts and implement solutions to the situation described above, without any further delay.

## *2) Safeguards in decision-making related to placements in public care*

As noted above, the Court found serious shortcomings in the decisions taken by the social care and medical authorities on the placement of Mr Câmpeanu once he had attained his majority and had to transition to the adult social protection system. Mr Câmpeanu was eventually transferred to and died at the neuropsychiatric hospital of Poiana Mare, although the authorities were fully aware of the extremely difficult conditions there, which had led to scores of patient deaths just before his transfer (§ 141).<sup>9</sup>

It is very concerning that the authorities have not indicated how they will guarantee non-repetition, since the information available from national monitoring bodies and from civil society shows that the shortcomings revealed in the judgment are not an isolated occurrence.

Civil society makes a strong point that the on-going process of de-institutionalisation, which is aimed at creating the conditions for people in residential social care facilities to transition to community-based, independent living, can bring a lasting solution to this issue.

However, given that this is a long-term process, the authorities must, in the meantime, provide for adequate and sufficient legal safeguards against arbitrariness in the relevant procedures. These must guarantee that the specific needs of these people are the paramount consideration in the decision-making related to placements, the continuing presence of people with disabilities in residential facilities, and transfers between such facilities or elsewhere, and that their will and preferences are duly ascertained and factored.

The authorities should thoroughly consider this matter and indicate, without delay, how they will guarantee non-repetition of this aspect of the substantive violation of Article 2 established in the judgment.

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<sup>9</sup> The Council of Europe's Committee for the Prevention of Torture and three United Nations Special Rapporteurs, among others, had alerted the Romanian authorities about the situation at that hospital at that time (2003-2004). Following the Court's judgment, the Committee of Ministers assessed the measures taken to improve the living conditions, treatment, and care afforded to patients in that hospital. At its Human Rights meeting in December 2017, it considered that no further measure was required as regards this hospital, given that the question of shortage of staff in psychiatric establishments was already examined in the case of *Parascineti*.

### 3) Effectiveness of criminal investigations

The NMC's activity report for the year 2021 shows that deaths in residential social care facilities are still not systematically notified to the investigating authorities, which precludes an independent determination of the cause of death, through a medico-legal autopsy.<sup>10</sup> It remains thus crucial that the authorities respond to the Committee's call and adopt without further delay, adequate and sufficient measures to resolve this issue.

As regards the other measures adopted to improve the effectiveness of relevant criminal investigations, it is not clear whether the authorities consider that these have sufficed to guarantee non-repetition of the violation of Article 2 found in relation to the investigation into the death of Mr Câmpeanu. The data they have provided so far only partially responds to the Committee's request. Although no definite conclusion can be drawn from it at this stage, the very high rate of cases, including of suspicious deaths, which are discontinued at pre-trial stage is worrying and requires further scrutiny.

The authorities should carry out a thorough qualitative analysis of the impact of the measures adopted so far and provide their conclusions to the Committee, including as regards any further action which may be needed to fully comply with their Article 46 obligations under the relevant judgment.

Such an analysis could draw on the findings and conclusions of the enhanced review introduced by the GPO in 2016 in respect of decisions to terminate such investigations (see CM/Notes/1280/H46-20) and should take into account all the aspects the Committee of Ministers outlined as relevant in its decision of June 2019, in particular when it comes to the concrete measures taken by the investigative authorities to ensure that victims' rights have been fully safeguarded in the investigations.

The analysis should moreover determine whether and to what extent the general obstacles to effective access to justice documented in a comprehensive study<sup>11</sup> which has served as basis for developing Romania's 2022-2027 National strategy for the rights of persons with disabilities, may have weakened the impact of those measures and may thus require swift corrective action.

Given the decisive role the NMC can have in combatting impunity, among others, it is also crucial for the authorities to ensure that it has at its disposal all the resources and means that it requires in order for it to be able to properly fulfil its mission.

### 4) Legal remedies

Based on the findings in the relevant judgment, the Committee has concluded that in order to guarantee non-repetition of the violation of Article 13, the authorities had to ensure accessible and effective legal remedies allowing people placed in residential social care facilities or in psychiatric establishments to bring Convention complaints related to their health and treatment before courts or other independent bodies.

In the absence of information from the authorities about the means they have chosen to comply with their Article 46 obligation under this head, it is observed that the domestic law includes provisions which appear relevant to the matter at stake. Under the current Civil Code, enacted in 2011, individuals can bring civil actions to seek judicial protection of their rights to life, health, physical and mental integrity, or dignity, among others. The courts have the power to put an end to the situation complained of, when they find that it breaches or may entail a breach of those rights, and to order compensation for any breach which may have already occurred (Articles 252 and 253). In the event of actual or imminent risk of irreparable harm, plaintiffs can request the courts to order precautionary measures, via an urgent procedure (Article 254).

These provisions could meet the requirements of Article 13 of the Convention when it comes to the scope and the redress domestic remedies must be able to provide in the situation at hand. The authorities should ascertain whether they can be relied on by residents in social care facilities and by patients in psychiatric establishments to bring complaints about the care they receive there.

<sup>10</sup> Available in Romanian at <https://www.consiliuldemonitorizare.ro>.

<sup>11</sup> The 2021 "Diagnosis of the situation of people with disabilities in Romania" prepared under a project implemented by the National Authority for the Protection of the Rights of Persons with Disabilities to strengthen the implementation of the CRPD in Romania, with funding from the International Bank for Reconstruction and Development (available in English at <https://anpd.gov.ro>).

They should also verify whether the domestic law has provisions to guarantee access in practice to such proceedings, for example through exemption from court fees and other forms of legal aid, where the plaintiff's situation so requires.

When it comes to how people placed in these institutions can make use of such remedies, the measures aimed at ensuring that they benefit from effective and independent legal representation, including when they do not have relatives able or willing to act on their behalf, are clearly relevant. Also relevant is the legislative change already implemented to grant NGOs *locus standi* to bring proceedings related to the rights and legitimate interests of these particularly vulnerable groups of people.

It is thus crucial that the Romanian authorities, on the one hand, swiftly implement solutions to guarantee adequate representation to all individuals placed in institutions who are in need of such protection, and, on the other hand, that they fully safeguard the existing possibilities for these people to have access to the mechanisms in place to ensure human rights compliance in and accountability for their treatment.

On this point, the case of the late Valentin Câmpeanu undoubtedly shows that NGOs working to protect and promote the rights of people with disabilities play a crucial role in detecting suspected cases of abuse or neglect of persons placed in institutions and in reporting them to the judicial authorities. It is thus fundamental that these NGOs can continue to fulfil this role including through monitoring visits in social care facilities and in psychiatric establishments.

Financing assured: YES
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## 1468<sup>th</sup> meeting, 5-7 June 2023 (DH)

### H46-22 Centre for Legal Resources on behalf of Valentin Câmpeanu and N. (No. 2) v. Romania (Applications Nos. 47848/08 and 38048/18)

Supervision of the execution of the European Court's judgments

Reference document  
CM/Notes/1468/H46-22

#### *Decisions*

#### The Deputies

1. recalling that these cases concern deficiencies in the legal protection system for adults with intellectual disabilities and with mental health conditions, in particular the drastic limitations it entailed to the protected persons' capacity to exercise their rights and the unavailability of adequate solutions to the situation of vulnerable adults who have no relative able or willing to act on their behalf;
2. recalling that *Centre for Legal Resources on behalf of Valentin Câmpeanu* also concerns other severe shortcomings in the social and medical care afforded to an orphaned young man with intellectual disabilities; the absence of an effective investigation into the circumstances of his death, which occurred after his unwarranted transfer to a psychiatric hospital; and the lack of legal remedies allowing for the examination of allegations concerning similar violations of Convention rights by an independent authority;
3. noted with satisfaction that in consequence of the Constitutional Court's decision of July 2020 ruling the guardianship system then in place unconstitutional, Parliament has enacted legislation introducing a new, gradual system of support and legal protection for vulnerable adults; welcomed the response the Romanian authorities have thus provided to the Committee of Ministers' relevant calls in the *Valentin Câmpeanu* judgment and to the European Court's subsequent findings and indications in *N. (No. 2)*;

#### *As regards individual measures*

4. invited the authorities to indicate whether Mr N. has availed himself of the possibility under the new legislation to request the courts to re-assess his situation and, in the affirmative, to inform the Committee about the status of the proceedings;

#### *As regards general measures*

5. as regards the new support and legal protection system, called on the authorities to closely monitor its implementation, in particular the ongoing re-assessment of the situation of those previously placed under guardianship, and to take every necessary measure to ensure that the new legislation is adequately and effectively applied; requested them in this context to address the concerns civil society has raised in relation to existing domestic capacities and to further arrangements needed to guarantee a swift and sound judicial determination of the situation of the individuals concerned;

6. strongly urged the authorities to redouble their efforts in order to enact, without any further delay, Convention-compliant solutions to the situation of those who, like Mr Câmpeanu, have no relative able or willing to take over support or representation duties under the new system, stressing that such solutions are crucial to ensuring effective access to justice for this particularly vulnerable group of people;

7. in that regard, emphasised moreover the imperative of ensuring human rights compliance in and accountability for the treatment of people with disabilities who are still placed in institutionalised, closed environments, pending the completion of the on-going process of transition to community-based, independent living;

8. recalled in this context that Romania has introduced in its legal order, with direct reference to the Court's findings in that judgment, provisions granting relevant civil society organisations *locus standi* in proceedings involving rights and legitimate interests of people with disabilities; urged the authorities to continue to allow these organisations access to these people in all types of facilities where they may be cared for so that those provisions and the protection they afford remain practical and effective;

9. as regards the other measures required to guarantee non-repetition of the violations in *Centre for Legal Resources on behalf of Valentin Câmpeanu*, noted the remaining questions outlined in the analysis prepared by the Secretariat for the present examination and requested the authorities to inform the Committee about the measures envisaged to address them;

10. requested the authorities to provide information on all aspects referred to above no later than 30 September 2023 and to keep the Committee duly informed thereafter; decided to resume consideration of these cases at the latest at their Human Rights meeting in June 2024.

## 1468<sup>th</sup> meeting, 5-7 June 2023 (DH)

Human rights

### H46-23 Parascineti, Cristian Teodorescu group, N., and R.D. and I.M.D. v. Romania (Applications Nos 32060/05, 22883/05, 59152/08 and 35402/14)

Supervision of the execution of the European Court's judgments

Reference documents

DH-DD(2023)354-rev, CM/ResDH(2022)49, CM/Del/Dec(2020)1377/H46-28, CM/Del/Dec(2022)1428/H46-23, H/Exec(2023)5

#### Action – Item proposed with debate

To debate the cases on the basis of the draft decisions below.

Application	Case	Judgment of	Final on	Indicator for the classification
32060/05	PARASCINETI	13/03/2012	13/06/2012	Complex problem
<b>CRISTIAN TEODORESCU GROUP</b>				
22883/05	CRISTIAN TEODORESCU	19/06/2012	19/09/2012	Structural problem
50131/08	ATUDOREI	16/09/2014	16/12/2014	
<b>N. GROUP</b>				
59152/08	N.	28/11/2017	28/02/2018	Structural problem
35402/14	R.D. and I.M.D.	12/10/2021	12/10/2021	

#### Cases description

These cases concern longstanding, structural deficiencies linked to overcrowding and inadequate living conditions, treatment and care afforded to patients and severe shortage in staff in psychiatric establishments in Romania (*Parascineti*); unlawful or arbitrary deprivations of liberty of patients involuntarily placed in such establishments, as protective measures under the Mental Health Act (*Cristian Teodorescu* group), or as security measures under the Criminal Code (*N.* and *R.D. and I.M.D.*); insufficient safeguards against such deprivations of liberty; systematic failure to seek consent to psychiatric treatment and absence of minimum legal safeguards attending the forcible administration of psychiatric treatment to involuntary patients (*Atudorei* and *R.D. and I.M.D.*).

The European Court found violations of the prohibition of inhuman and degrading treatment (Article 3), of the right to liberty and security (Article 5) and of the right to physical and moral integrity (Article 8).

#### Status of execution

##### Individual measures:

The just satisfaction awarded by the Court for non-pecuniary damage and costs and expenses was paid.

At its previous examinations, the Committee of Ministers concluded that no individual measures were required in *Parascineti* and in the cases of the *Cristian Teodorescu* group, as the applicants had all regained their liberty by the time the European Court gave its judgments.

<sup>1</sup> This document has been classified restricted until examination by the Committee of Ministers.

In *N.*, following the Court's judgment finding that his continued psychiatric detention was arbitrary, the applicant was released from psychiatric hospital, where he had been detained for over 17 years. The authorities secured his transfer to community-based sheltered housing, suited to providing him the significant level of medical and social support, and care needed after his long confinement.

At its September 2021 examination, the Committee welcomed these developments, but considered that the authorities' obligation to provide *restitutio in integrum* further entailed that the arrangements made to allow for the applicant's release from psychiatric hospital into the community remain in place as long as his situation so requires. It therefore requested the authorities to continue to monitor the situation, take every necessary measure for this purpose and keep it informed.

No change in the applicant's situation has been reported since.

In *R.D. and I.M.D.*, the authorities informed the Committee that the relevant court had ordered the applicants' release from psychiatric hospital, on the condition that they follow outpatient psychiatric treatment. The applicants had been therefore released in February 2022 and in September 2021, respectively (DH-DD(2022)656).

### General measures:

#### **A. Previous examinations by the Committee of Ministers**

- 1) *Parascineti and Cristian Teodorescu group (overcrowding, poor living conditions, treatment, and care in psychiatric establishments; wide-scale deficiencies in the application of the procedures and insufficient safeguards attending involuntary placements under the Mental Health Act; systematic failure to seek these patients' consent to psychiatric treatment)*

The Committee examined these cases at its September 2016, December 2019, and June 2020 Human Rights meetings (1265<sup>th</sup>, 1362<sup>nd</sup> and 1377<sup>th</sup>).

It found that the measures put forward by the authorities up to 2016 had not sufficed to address the deficiencies revealed by the judgments. This was attested by reports of the Ombudsperson, including in its capacity of National Preventive Mechanism, and of the European Committee for the Prevention of Torture (CPT), which also provided indications on the root causes and the remedial action required to address them (for details, see CM/Notes/1265/H46-22 and CM/Notes/1362/H46-18).

In December 2019, the Committee expressed deep concern at this situation and strongly regretted the absence of any response from the authorities to its previous call for additional wide-ranging measures. It underlined that a strong and enduring commitment in particular from decision-makers was required to bring about adequate and lasting solutions. It firmly called on the authorities to develop a comprehensive action plan setting out measures rapidly to address the root causes of the violations and to take all necessary action to ensure their effective and timely implementation. It also strongly encouraged them to rely on the relevant findings and recommendations of the Ombudsperson and on those of the CPT.

At the last examination, in June 2020, the Committee noted the information provided by the authorities that relevant ministries and agencies were working to develop the requested action plan, despite the difficulties caused by the Covid-19 pandemic. It called upon the authorities to continue making all possible efforts with a view to completing and submitting the action plan as expeditiously as possible.<sup>2</sup>

- 2) *N. (structural deficiencies in relation to decisions to prolong psychiatric detention imposed as security measures under the Criminal Code and to safeguards against arbitrary or unlawful deprivations of liberty in this context)*

The Committee examined this case at its December 2018, September 2021, and March 2022 Human Rights meetings (1331<sup>st</sup>, 1411<sup>th</sup> and 1428<sup>th</sup>).

<sup>2</sup> The authorities provided in October 2020 information on several lines of action defined in this area by the mental health public policy agency, but it later emerged that this work had not been endorsed by relevant decision-makers, in particular the Ministry of Health.

In Interim Resolution CM/ResDH(2022)49, adopted at the last examination, the Committee reiterated its grave concern at the authorities' failure to provide information on any concrete measure taken or envisaged to address the structural deficiencies found by the Court. It underlined again, with great concern, the high risk of repetition of such violations in respect of individuals belonging to a particularly vulnerable group.

The Committee exhorted the authorities, at the appropriate level, to take, as a matter of urgency, all necessary action with a view to ensuring that the measures required to put an end to, and guarantee non-repetition of the violations were defined and implemented without any further delay. It urged them to strengthen their dialogue with the Committee in the process of supervision of the execution of the judgment and strongly encouraged them to engage in high level consultations with the Secretariat on how this could be achieved. It requested the authorities to inform it of the measures planned and the timetable set for their implementation without any further delay and in any event no later than 1 September 2022.

- 3) R.D. and I.M.D. (*insufficient legal safeguards attending decisions to impose psychiatric detention as security measures under the Criminal Code and lack of minimum legal safeguards against forcible administration of medication of patients subjected to such detention*)

This is the Committee's first examination of the case.

## B. Latest developments

### 1) High level consultations and exchanges at technical level

The cases were discussed during high-level consultations held in Bucharest on 5-7 April 2022 between the Director of Human Rights, staff from the Department for the Execution of Judgments, and representatives of national authorities including the Head of the Prime Minister's Chancellery, officials in relevant ministries, and the parliamentary Human Rights standing committees. The Council of Europe delegation also met the Ombudsperson and representatives of civil society.

In June 2022, the Department had further exchanges, primarily at technical level, with officials from some of the relevant authorities. These focused on the general measures required to implement these and other judgments finding violations of the rights of people with mental health conditions or with intellectual disabilities. Representatives of the relevant national monitoring bodies also attended the exchanges.

### 2) Ongoing actions at national level

The authorities provided updated information on 23 March 2023 (see DH-DD(2023)354-rev for details), which is summarised below.

- Preparation of a national action plan for the prevention of ill-treatment in psychiatric establishments and residential social care facilities

In December 2022, the Senate Human Rights standing committee and the NGO Centre for Legal Resources held a public debate focused on Romania's obligation to implement the European Court's judgments finding violations of fundamental rights of people with mental health conditions or with intellectual disabilities. The event brought together officials from relevant government departments (notably the Ministry of Health and its specialist agency, the Ministry of Labour and Social Solidarity, and the Ministry of Justice) and other stakeholders to discuss about the content of such a national action plan.

The submissions note that the exchanges provided important input to the competent national authorities that will be tasked with preparing the action plan.

They further refer to a project implemented jointly by the Centre for Legal Resources and the General Prosecutor's Office (AdaptJust) with EEA and Norway Grants funding, aimed specifically at supporting the execution of these judgments. Its objectives include the preparation of a national action plan similar in scope to the one mentioned above. Part of the training sessions organised in the framework of this project (below) are dedicated to discussing its possible content.

- Strategy developed by the National Centre for Mental Health and the Fight against Drugs<sup>3</sup>

It is indicated that this agency has a strategy to develop its institutional capacity and to attract funding to be able to implement a series of objectives over 2023-2028. These include (i) supporting interinstitutional working groups to map out existing resources and needs in the mental health care system and to review the relevant legislation; (ii) elaborating and implementing solutions to the issues thus identified; (iii) improving working conditions for mental health professionals and providing them with human rights training including in the context of involuntary psychiatric placements; (iv) supporting the creation of new professions in the field of mental health care and related disciplines (such as occupational therapy and forensic psychiatry and psychology).

- Capacity building for relevant professionals (judges, prosecutors, psychiatrists, psychologists, forensic doctors, lawyers, social care workers)

The National Institute for the Judiciary organised two workshops in 2022 on hearing techniques in criminal proceedings, with emphasis on interaction with vulnerable persons. In 2023, it will organise an interdisciplinary training session for twenty judges, prosecutors, lawyers, forensic doctors, and psychiatrists, with focus on the Court's case-law on psychiatric medical assistance. This comes in addition to other training activities the Institute has organised on human rights protection and on combatting discrimination.

The joint project implemented by the Centre for Legal Resources and the General Prosecutor's Office also includes capacity building for these professionals (training of trainers in 2022, followed by twenty interdisciplinary training sessions across the country in 2022-2023, on topics of relevance for the execution of these and other judgments of the Court; 261 participants received training during the first 12 sessions).

- National monitoring bodies

Romania established in 2016 a National Council responsible for monitoring the implementation of the UN Convention on the Rights of Persons with Disabilities (CRPD). This autonomous body has mostly focused so far on the situation in social care facilities for people with disabilities; it is now taking steps to strengthen its capacity to monitor human rights compliance in psychiatric establishments.

The Ombudsperson, in its capacity of National Preventive Mechanism, has continued to visit psychiatric establishments (24 visits between 2019 and 2023) and to make recommendations to address shortcomings such as insufficient staffing, poor material conditions, non-observance of the provisions on involuntary placements and of those relating to consent to treatment. Recommendations were also issued for legislative change to address some of the shortcomings found.

### 3) *Action by other Council of Europe bodies*

The CPT carried out an *ad hoc* visit to Romania from 19 to 30 September 2022 focused on the treatment of patients held in psychiatric establishments and of people accommodated in residential care facilities. At the time of drafting these Notes, the report on this visit has not yet been published.

The Rapporteur of the Parliamentary Assembly of the Council of Europe carried out a fact-finding visit to Romania on 15-16 November 2022, during the preparation of the 11<sup>th</sup> Report on the Implementation of judgments of the European Court of Human Rights.<sup>4</sup> These cases were amongst the specific judgments discussed during the visit.

### Submissions from civil society (Rule 9 (2))

The Committee received two submissions from the Centre for Legal Resources on 21 April 2023 (see DH-DD(2023)538 and DH-DD(2023)539 for full details).

<sup>3</sup> This is a public agency subordinated to the Ministry of Health tasked with coordinating, implementing, and evaluating mental health public policies. According to the information published on its website, it currently employs five staff members.

<sup>4</sup> The Report with a link to the Information note following the Rapporteur visit is available here.

The Centre for Legal Resources regrets that the authorities' last submissions fail to meaningfully address the concrete aspects which are relevant to their obligation to implement these judgments. It stresses that on-site visits it has carried out and data it has collected, findings of national monitoring bodies and reports in mass media confirm that the serious deficiencies revealed by the judgments persist. It draws the Committee's attention to the fact that the present capacity of psychiatric establishments in Romania is of 16,073 beds, which gives a general indication about the number of people which may be affected.

The NGO makes detailed recommendations for remedial action. It considers in particular that establishing community-based mental health and social care services is key to addressing the root causes of many of the deficiencies, including overuse of involuntary measures and ensuing overcrowding in psychiatric establishments. It proposes legislative changes to remedy the shortcomings and to strengthen the legal safeguards and measures to guarantee that the relevant procedures and safeguards are rigorously applied.

It considers that a co-ordinator should be appointed at government level specifically for the execution of these judgments. It also advocates for institutional change to ensure that the coordinating mechanism for the implementation of the CRPD established within government has clout over the Ministries of Health and of Labour and Social Solidarity, which oversee facilities where people with disabilities are placed.

The NGO calls for the urgent submission to the Committee of an action plan with concrete measures to implement these judgments and asks the Committee to consider increasing the frequency of its examinations and adopting a new interim resolution if the situation so requires.

### **Analysis by the Secretariat**

#### Individual measures:

The Committee may wish to close its supervision of the question of individual measures in *Parascineti* and in the two cases of the *Cristian Teodorescu* group.

As regards the case of *N.*, the Committee's request to the authorities to continue to monitor the situation, in order to make sure that the arrangements made to allow for the applicant's release from psychiatric hospital into the community stay in place as long as his situation so requires, remains valid, given the impasse in the adoption of relevant general measures (see below).

In *R.D. and I.M.D.*, the violations stem from the absence of sufficient legal safeguards attending on the one hand, decisions to detain individuals who fail to comply with court orders imposing on them an obligation to undergo outpatient psychiatric treatment, and, on the other hand, the administration of psychiatric treatment to these patients, whilst detained.

As the applicants' release is subject to the condition that they follow outpatient psychiatric treatment, their situation appears linked to the adoption of the general measures required to introduce the necessary safeguards in the domestic legal order.

#### General measures:

Document H/Exec(2023)5 prepared by the Department for the Execution of Judgments provides details of the violations and their context and includes other information relevant for identifying the actions required to bring them to an end to and guarantee their non-repetition.

In particular, the document highlights the main findings and recommendations for remedial action in a landmark Ombudsperson Report on human rights compliance in psychiatric establishments in Romania, published in November 2019.<sup>5</sup> Many of these are echoed in the recent submissions received from civil society.

The Ombudsperson Report looks into many of the aspects which are relevant for the execution of these judgments, and finds persisting overcrowding, poor living conditions, treatment and care afforded to patients and chronic shortages in all categories of staff in psychiatric establishments in Romania.

<sup>5</sup> The Report is available in Romanian at <https://avp.ro/index.php/activitatea-avp/rapoarte-speciale>.

It also looks into the situation of patients who, like the applicant in *N.* at the time of the judgment, are not or are no longer in need of psychiatric hospitalisation but cannot be discharged. On this point, like on others, the Report finds systemic failures, linked in this case to gaps in the legislation and to the incapacity of the mental health and social care systems to provide community-based accommodation, support, and treatment to these patients after discharge. The Centre for Legal Resources identified over 2,000 people in this situation between 2017 and 2018.

The above elements reflect only some of the deficiencies revealed by these judgments: those the European Court found to breach the absolute prohibition of inhuman and degrading treatment, as far back as 2012 (*Parascineti*), or to amount to arbitrary deprivations of liberty (*N.*), in 2018.

More recently, in *R.D. and I.M.D.*, the Court established that the domestic law contains no provisions regulating the administration of psychiatric treatment to an entire category of involuntary patients and is devoid of safeguards to protect them against forcible administration of such treatment. The risk of repetition of the Article 8 violation found on account of such gaps in the domestic legal order is very high.

The Committee of Ministers has already stressed the humanitarian aspect of some of the violations. It has voiced its grave concern at the authorities' significant delay in implementing the judgments and at the high risk of new violations this entailed in respect of individuals belonging to a particularly vulnerable group, historically subject to prejudice with lasting consequences, resulting in their social exclusion.

It has therefore made increasingly urgent calls, in its decisions and in the above interim resolution, for a strong and enduring commitment and for involvement of the authorities at decision-making level to define lasting solutions and to ensure their effective and timely implementation.

The Secretariat has recalled the Committee's grave concerns and has endeavoured to represent its urgent expectation of remedial action, in particular during its high-level consultations with the Romanian authorities, which took place more than a year ago.

Against this backdrop, it is noted with the outmost regret that the authorities' response, so far, falls short of those expectations: they have not put forward comprehensive measures to address the deficiencies or at least shown that government departments with key roles and responsibilities are now engaged in devising a strategic, comprehensive, and co-ordinated response, including when it comes to securing financial provisions to back up the execution action required.

The authorities did refer to initiatives promoted by the mental health public policy agency and by civil society actors. The lines of action the former has put forward could enable the development of solutions to some the issues raised in these cases. The latter are already steering a process at grassroots level to define and advance solutions for the implementation of these judgments and have put forward concrete and relevant proposals for remedial action in their recent submissions to the Committee.

However, the authorities have not specified how these initiatives are relevant to their action to execute these judgments. It is not clear from their submissions that the proposals put forward by the specialist public agency have the support of the relevant decision-makers, including when it comes to increasing this agency's capacity to deliver on those objectives. It is also not clear whether or how the government departments concerned, notably the Ministries of Health, of Labour and Social Solidarity and of Justice, are drawing or intend to draw on the work done by civil society in order to define the execution actions required.

Most significantly, the submissions remain silent on how the authorities will ensure impetus, direction, and co-ordination, especially in the areas where concerted and in some respects urgent remedial action is needed from different parts of the government (see H/Exec(2023)5 for details).

In the light of the foregoing, the Committee may wish to exhort again the authorities, at a high political level, to show the firmest determination and commitment and ensure that a clear, full, and coherent strategy to lastingly address all the deficiencies revealed by these judgments is put forward without any further delay. It could also emphasise the input of the specialist public agency and the significant support civil society can bring to this process.

In this work, the authorities should also rely on the findings and recommendations from the Romanian Ombudsperson, whose sustained efforts, including in its capacity of National Preventive Mechanism, to uphold respect for the fundamental rights of patients in psychiatric establishments could be again recognised.

The Committee may moreover wish to call the authorities' attention to the Secretariat's analysis in document H/Exec(2023)5, in particular its concluding general remarks on the execution action required and the urgent priorities in this context. It could urge them to draw on this and on the Council of Europe's other relevant expertise and works, including the CPT's general and specific recommendations in the fields concerned. It could also offer further technical assistance and co-operation from the Organisation in the execution process.

Given the humanitarian aspect of the violations, the long time passed since the judgments have been under its supervision and the urgent need for the authorities to scale up their commitment in order to overcome their present impasse and advance the execution process, the Committee could also consider inviting member States to raise in their contacts with the Romanian authorities the issue of their implementation.

For the same reasons, it may wish to resume rapidly its examination of these cases, and, in the absence of significant progress towards the completion and the adoption of an action plan to address fully and lastingly the structural deficiencies revealed by these judgments, to instruct the Secretariat to prepare a draft interim resolution for their consideration at the relevant meeting.

Financing assured: YES
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## 1468<sup>th</sup> meeting, 5-7 June 2023 (DH)

### H46-23 Parascineti, Cristian Teodorescu group, N., and R.D. and I.M.D. v. Romania (Applications Nos 32060/05, 22883/05, 59152/08 and 35402/14)

Supervision of the execution of the European Court's judgments

Reference document  
CM/Notes/1468/H46-23

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#### *Decisions*

##### The Deputies

1. recalled that these cases concern longstanding structural problems linked to overcrowding and inadequate living conditions, treatment and care for patients in psychiatric establishments in Romania; unlawful or arbitrary deprivations of liberty of patients involuntarily placed in such establishments; and deficiencies in the relevant procedures and in the safeguards attending involuntary placements and the psychiatric treatment given to these patients;
2. underlining that these issues relate to the rule of law and also raise humanitarian concerns with regard to individuals belonging to a particularly vulnerable group, historically subject to prejudice with lasting consequences, resulting in their social exclusion;

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##### *As regards individual measures*

3. recalled that the applicants in *Parascineti*, *Cristian Teodorescu* and *Atudorei* had all regained their liberty by the time the European Court gave its judgments and that no further measures are required in respect of their situation; decided to close their supervision of the individual measures in these cases;
4. reiterated, in respect of the applicant in *N.*, their call on the authorities to continue to monitor the situation in order to make sure that the arrangements made to allow for his release from psychiatric hospital into the community remain in place as long as his situation so requires, as entailed by their obligation to provide *restitutio in integrum* to the applicant;
5. noted that the applicants in *R.D. and I.M.D.* have been released from psychiatric detention on the condition that they follow outpatient psychiatric treatment; considered, given the legislative deficiencies underlying the violations in this judgment, that their situation is linked to the general measures required to remedy these;

##### *As regards general measures*

6. recalling their decisions in these cases and Interim resolution CM/ResDH(2022)49 adopted in the case of *N.*, and the Committee's heightened concerns at the persistence of the structural deficiencies revealed by the judgments and at the prolonged failure by the Romanian authorities to take action in order to put an end to and guarantee non-repetition of the violations;

7. noted the findings in the Romanian Ombudsperson's Report on human rights compliance in psychiatric establishments in Romania, outlined in document H/Exec(2023)5 prepared by the Secretariat, and the recent civil society submissions attesting yet again the urgent need for remedial action and expressed their outmost concern at the high risk of further violations this situation entails;
8. noted with interest the recent promising initiatives driven by public stakeholders and civil society geared towards defining and advancing solutions, but strongly deplored the lack of any indication that the authorities, in particular government departments with key roles and responsibilities, are now engaged in devising a strategic, comprehensive, and co-ordinated response to the judgments, including when it comes to securing financial provisions to back up the action required;
9. exhorted therefore once more the Romanian authorities, at a high political level, to demonstrate the firmest determination and commitment by providing impetus, direction, and co-ordination to the action required to implement the judgments;
10. strongly urged them to submit to the Committee, by 30 September 2023 at the latest, a clear and precise roadmap with a tight timetable for the completion and for the adoption at the highest level of government of a comprehensive action plan to address fully and lastingly the structural deficiencies revealed by these judgments, putting to good use the initiatives driven by public stakeholders and by civil society and the work done in this context;
11. urged the authorities to rely also on the Ombudsperson's relevant findings and recommendations in their work to define such solutions, expressing once more their appreciation for this institution's sustained efforts to uphold respect for the fundamental rights of patients in psychiatric establishments, including in its capacity of National Preventive Mechanism;
12. called moreover the authorities' attention to the Secretariat's analysis presented in document H/Exec(2023)5 and its concluding general remarks on the execution action required and on the urgent priorities in this context; urged them to draw on this and on the Council of Europe's other relevant expertise and works, including those of the European Committee for the Prevention of Torture, bearing in mind the further support the Council of Europe can provide to the execution process through technical assistance and co-operation;
13. in view of the humanitarian aspect of the violations found and the urgent need to overcome the impasse in addressing them and advance the execution process, invited the authorities of the Council of Europe member States to raise the issue of the implementation of these judgments in their contacts with the Romanian authorities;
14. decided to resume the examination of these cases at their Human Rights meeting in March 2024 and, in the absence of significant progress towards the completion and the adoption of the required action plan, instructed the Secretariat to prepare a draft interim resolution for consideration at that meeting.



H/Exec(2023)5 23/05/2023

## ***Parascineti* (Application No. 32060/05), *Cristian Teodorescu* group (Application 22883/05) and *N.* group (Application No. 59152/08) v. Romania**

Analysis of the general measures

Memorandum prepared by the Department for the Execution of Judgments of the European Court of Human Rights

*The opinions expressed in this document are binding on neither the Committee of Ministers nor the European Court.*

This document should be seen as a complement to the notes prepared for the examination of the cases above for the 1468<sup>th</sup> meeting of the Committee of Ministers (June 2023) (DH). It provides a more detailed overview of the European Court's findings and includes other information relevant for the identification of the measures required to put an end to and guarantee non-repetition of the violations.

### I. Overview of the issues under consideration

#### A. Issues examined in *Parascineti* (judgment final on 13 June 2012)

**Issues:** In this case, the European Court found a violation of the prohibition of inhuman and degrading treatment (Article 3) during the applicant's involuntary placement in the psychiatric unit of the Sighetu Marmăției Hospital in July 2005,<sup>1</sup> due to overcrowding, poor sanitary and hygiene conditions, including the absence of an individual bed, and the impossibility to spend time outdoors due to staff shortages.<sup>2</sup>

**Scope, persistence, and root causes:** From the early stages of the execution process, the Committee of Ministers formed the view that similar problems affected to some degree many of the existing psychiatric establishments in Romania. This was evidenced, among others, by reports of the European Committee for the Prevention of Torture (CPT)<sup>3</sup> and of the Romanian Ombudsperson, including in its capacity of National Preventive Mechanism, which also provided indications concerning the root causes of such deficiencies and the measures required to address them.

More recently, an Ombudsperson Report on human rights compliance in psychiatric hospitals in Romania, published in November 2019 ("the Report"), found that:

<sup>1</sup> Despite information provided by the authorities up to 2016 that measures had been taken and were underway to improve the conditions in this unit, the Ombudsperson found in September 2019 overcrowding and poor material and hygiene conditions in several sections, including one situated in the basement which offered wholly inadequate conditions. It also found that the unit continued to face shortages in all categories of staff. It concluded that these conditions affected the patients' human dignity and amounted to degrading treatment.

<sup>2</sup> The Committee of Ministers examines the question of domestic remedies in relation to such complaints in the case of *Centre for Legal Resources on behalf of Valentin Câmpeanu*, where the European Court has found a violation of Article 13.

<sup>3</sup> The CPT carried out an *ad hoc* visit to Romania from 19 to 30 September 2022 focused on the treatment of patients held in psychiatric establishments and of people accommodated in residential social care facilities. At the time of drafting this document, the report on this visit has not yet been published.

- *overcrowding is still an issue in many psychiatric hospitals, particularly in those which are authorised to implement psychiatric detention<sup>4</sup> and in hospitals for chronic patients.*

As underlying factors, the Report highlights the great pressure on psychiatric hospitals to admit patients, against the background of a shortage of community mental health services. It finds that some hospitals, already operating above capacity, have waiting lists and also notes an increase in the number of patients subject to psychiatric detention (see also group N. below). It recommends that the Ministry of Health draw up a plan of urgent measures to combat overcrowding in psychiatric hospitals/units and to ensure compliance with the general standards for accommodation of patients in hospitals in Romania.

The Report further brings into focus the situation of patients termed as "social cases", that is those who can be discharged but have lost family and community ties and need alternative arrangements allowing them to receive suitable medical and social care and support in community; many of these patients have long been in psychiatric hospital.<sup>5</sup> It notes that there continue to be cases where the courts maintain psychiatric detention without medical necessity, because patients cannot receive outpatient support and follow-up including to ensure that they would undergo compulsory medical treatment which the courts can impose as a condition for their release (see also the N. group below). In other reports drawn up following on-site visits,<sup>6</sup> the Ombudsperson observed that people with intellectual disabilities are placed in or transferred to psychiatric hospital from social care facilities for extended stays, even though these hospitals are not suitable facilities to care for these people.

The Report notes that steps taken by hospitals to liaise with social welfare authorities have not yielded results and points out to the lack of genuine interest to find solutions for these patients. It recommends that the Ministry of Health identify, together with other relevant public authorities and stakeholders, solutions allowing to reintegrate these people into community. At legislative level, it calls for supplementing the mental health legislation with provisions on de-institutionalisation of patients who no longer require hospitalisation and on multidisciplinary (medical and social), integrated and inter-institutional care measures and monitoring in community.

- *material conditions remain generally problematic*

The Report notes that, with some exceptions, the conditions afforded to patients are unsatisfactory: living space is insufficient, wards are in a poor state of repair, sanitary facilities are rundown and insufficient given the number of patients, and the infrastructure unsuited for some of these hospitals to carry out activities in accordance with the relevant standards and in safe conditions for patients. It recommends that the Ministry of Health consider rehabilitation work in the facilities under its responsibility which are in an advanced state of disrepair.

- *psychiatric hospitals continue to face serious staff shortages.*

The Report considers the situation with regard to doctors, nurses, care assistants, and janitors (this includes staff responsible for overseeing the patients). It finds issues with unfilled vacancies, in particular for doctors, and outlines some other systemic issues in relation to the status, levels, and training of overseeing staff and the serious consequences these have on patient and staff safety and on human rights compliance in the way patients are treated. It also considers that the general norms on hospital staffing are inadequate for psychiatric hospitals and should be adapted by increasing the number of posts allocated to these hospitals.

The Report does not address in detail the situation for other categories of staff, such as psychologists, therapists, and social welfare assistants, which, by law, should be part of the therapeutical teams in

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<sup>4</sup> Psychiatric detention can be imposed by criminal courts as a security measure during or at the end of criminal proceedings. The four hospitals authorised to implement psychiatric detention ordered at the end of criminal proceedings are located in Bihor County (Ștei), Buzău County (Săpoca), Iași County (Pădureni Grajduri), and Timiș County (Jebel).

<sup>5</sup> The NGO Centre for Legal Resources reported that it had identified over 2,000 people in this situation between 2017 and 2018 (DH-DD(2023)546).

<sup>6</sup> Reports by the Ombudsman on the visit to the Gura Văii psychiatric hospital (ward for chronic adult patients), published on 11 September 2017, and the visit to the Pădureni-Grajduri secure psychiatric hospital, published on 9 September 2019.

charge of patients.<sup>7</sup> It observes nevertheless that in one hospital, the lack of such specialist staff meant that patients could not benefit from suitable therapies and meaningful activities.<sup>8</sup>

The Report recommends legislative, policy, capacity-building and other practical measures to address these shortcomings, including to fill in existing vacancies and to ensure individualised and suitable therapeutic care to patients in such hospitals.

- *funding for psychiatric hospitals*

The Report indicates that the four hospitals authorised to implement psychiatric detention are under the responsibility of the Ministry of Health and the other hospitals under that of county councils or of local councils. It recommends to the Ministry of Health to envisage transferring these latter hospitals under the responsibility of county councils, for better funding, and to identify new means to financially support the mental health system, including through national programmes or through projects to attract dedicated funding. It also makes specific recommendations for the funding of the four secure hospitals, namely that part of their operational costs is taken over by the Ministry of Justice.

In its concluding remarks, the Report expresses concerns about the conditions in which patients live and staff work in some of these hospitals; the staff's insufficient training for a balanced approach between the task of overseeing patients and the imperative of respecting their fundamental rights; the inadequate statutory framework on staffing and professional training in relation to the specific needs in the mental healthcare system; the fact that alternative therapies, which should support the patients' recovery, are practically non-existent in these hospitals, and patients are not offered a coherent system of mental health monitoring, including after discharge. It concludes that these stem from an outdated mental health system that is still allowing patient mistreatment and abusive restraint practices and needs new public policies and adequate budget provisions to implement these.

**B. Issues examined in the *Cristian Teodorescu* group<sup>9</sup> (judgments final on 19 September 2012 and 16 December 2014)**

**Issues:** The cases in this group concern violations of the right to liberty and security (Article 5) and of the right to physical and moral integrity (Article 8), in relation to involuntary placements implemented as protective measures under the Mental Health Act and to the medical treatment of such patients.<sup>10</sup>

The European Court found that the applicants had been placed in psychiatric hospital (or arrested by the police with a view to such placement) without compliance with the procedure prescribed by the Mental Health Act and without any justification relating to their mental health condition.

In one case (*Atudorei*), the Court also found that the psychiatrist who had attended the applicant had failed to observe the legal requirement to obtain her consent to the medical treatment provided during her placement or, absent such consent, to submit this treatment for validation to a medical commission, as required under the relevant provisions of the Mental Health Act.

The Court observed that these violations had occurred in the context of shortcomings in the provisions governing the procedure and safeguards in the field of involuntary placement at the material time (2004-2008), as well as more general problems which affected the application of the Mental Health Act. It highlighted that the Ministry of Health's failure to designate the hospitals authorised to proceed with involuntary placements, coupled with patchy knowledge among medical personnel of the procedures under this Act, had rendered its application difficult and inconsistent (*Atudorei*, §§ 85-87 and 149).

<sup>7</sup> The implementing regulations to the Mental Health Act stipulate that any psychiatric facility should provide at least the following medical services: a) diagnosis and treatment of acute and chronic mental disorders; b) psychological assessments; c) counselling and psychoeducation for patients and their families; d) occupational, educational and recreational therapy programmes.

<sup>8</sup> The CPT has long pointed out that the treatment of patients in psychiatric hospitals in Romania is almost exclusively based on medication. In the Report on its visit to Romania in 2014 (CPT/Inf (2015) 31), the CPT recommended expanding the range of therapeutic options, in particular for long-term patients, and developing for each patient a multidisciplinary treatment plan adapted to their specific needs. Patients had to be involved in the development of their plan and informed about the progress made.

<sup>9</sup> This group now consists of two leading cases (*Cristian Teodorescu* and *Atudorei*). The Committee closed its supervision of two repetitive cases (*Comoraşu* and *Ulisei Grosu*), where the individual measures had been settled (CM/ResDH(2022)340).

<sup>10</sup> The Mental Health Act (Law No. 487/2002) authorises psychiatric placements without the patients' consent, where a psychiatrist determines that an individual suffers from a mental disorder and that (i) he/she represents an imminent danger to himself or herself or to others or that (ii) in case of individuals suffering from serious mental disorders, non-admission could lead to a serious deterioration in their condition or prevent them from receiving appropriate treatment.

**Scope, persistence, and root causes:** The Committee of Ministers concluded that amendments brought to the Mental Health Act in 2012 had rectified the legislative shortcomings identified by the Court in the procedure and safeguards attending involuntary placements.<sup>11</sup> At the same time, the Committee noted that while those amendments had subjected the initial placement decisions to *ex officio* judicial review, no such review was provided in respect of decisions to renew involuntary placements, which are left entirely to relevant hospital commissions. Concerned that this may lead to unjustified renewals of such placements and thus aggravate overcrowding in psychiatric hospitals, the Committee asked the authorities to fill this gap. This request remains so far unanswered.

When it came to the failure of the relevant mental health professionals to apply the procedure for involuntary placement, the Committee found that this issue remained unaddressed. It relied on reports of the Ombudsperson evidencing not only shortcomings in the application of the legal procedure and safeguards but also situations where the relevant legal provisions seemed to have been circumvented and patients subjected to *de facto* involuntary placements. The reports also highlighted problems in judicial review proceedings of initial placement decisions, which prompted the Ombudsperson to recommend further amendments to the Mental Health Act,<sup>12</sup> while expressing concern that the medical and judicial authorities competent to decide, validate and review such placements did not seem fully to appreciate that these amount to deprivations of liberty.<sup>13</sup>

In its 2019 Report on human rights compliance in psychiatric hospitals, the Ombudsperson further observed that the Ministry of Health had still not complied with existing regulations requiring it to designate the hospitals authorised to proceed to involuntary placements. It expressed on this account concerns about the legality of any such placements implemented under the Mental Health Act.

The Romanian authorities have never addressed in their submissions to the Committee the Article 8 violation found because of the psychiatrists' failure to observe the provisions and safeguards attending consent to psychiatric treatment, even though the Ombudsperson's reports continued to show that these were still not consistently applied.<sup>14</sup> The CPT on its part found during its visit in 2014, against the backdrop of some inconsistencies in the implementing regulations to the Mental Health Act, that medical personnel did not seek consent to treatment separately from consent to placement. When it came to patients subjected to involuntary placements, the placement decision was understood to exempt psychiatrists from the obligation to seek these patients' consent to psychiatric treatment.<sup>15</sup>

## **B. Issues examined in *N. and R.D. and I.M.D.* (judgments final on 28 February 2018 and 12 October 2021)**

**Issues:** These cases concern violations of the right to liberty and security (Article 5) and of the right to physical and moral integrity (Article 8), in relation to psychiatric detention and treatment imposed as security measures under the Criminal Code either directly (*N.*) or due to an individual's failure to comply with a previous court order imposing on him/her an obligation to undergo outpatient medical treatment for a diagnosed mental disorder (*R.D. and I.M.D.*).

### **Details and context of the violations:**

- i. insufficient legal safeguards attending psychiatric detention of individuals who fail to comply with court orders imposing on them an obligation to undergo outpatient psychiatric treatment (violation of Article 5, paragraph 1 in *R.D. and I.M.D.*).

The Court found that this violation was rooted in legislation (§ 62). Indeed, in such cases the relevant provisions (Article 568 § 1 of the Code of Criminal Procedure) require courts to impose detention without the benefit of a recent specialist examination and without allowing them to verify on this basis whether the mental disorder persists and is of a kind or a degree warranting psychiatric detention.

<sup>11</sup> These were related to the conditions and procedure for the notification of the decisions to proceed to or validate an involuntary placement, which are taken by medical commissions established at hospital level (see CM/Notes/1265/H46-22 for details).

<sup>12</sup> To ensure that patients subjected to involuntary placements receive free legal aid and to make it mandatory for the courts to request an independent expert opinion in review proceedings of initial placement decisions.

<sup>13</sup> See CM/Notes/1362/H46-18 for details.

<sup>14</sup> *Ibidem*.

<sup>15</sup> The same is valid for patients subjected to psychiatric detention (see *R.D. and I.M.D.*).

- ii. unlawful psychiatric detention due to the failure of the relevant courts to assess and justify the need to prolong such measures based on the seriousness of the patients' psychiatric condition and the risk this poses to themselves or to others, and to consider whether less severe measures would suffice to counter any such risk (violation of Article 5, paragraph 1 in *N.*).

In *N.*, the Court found that the applicant's deprivation of liberty between 2007 and 2016 was devoid of legal basis, mainly because the domestic courts had failed to assess the danger he posed to society, which was an essential element under domestic law, but instead based themselves only on forensic medical reports attesting that he had a psychiatric condition. Neither the medical authorities nor the courts had considered whether any alternative measures might have been implemented in his case. In addition to being contrary to domestic law and Article 5 § 1, the detention was inconsistent with the principle that the sole existence of a disability shall in no case justify a deprivation of liberty, laid down in the United Nations Convention on the Rights of Persons with Disabilities (§§ 154 – 159).

In *R.D. and I.M.D.*, while the violation concerns only the initial detention order (above), the Court observed that the forensic psychiatric examinations carried out in the years immediately following that order had been very cursory, contained insufficient information on the medical reasoning and the clinical examinations conducted and did not establish that the applicants were dangerous to themselves or to society. As of 2018, the expert reports became much more detailed, and the court decisions gave precise reasons for the need to maintain the detention. The forensic medical reports and the court decisions showed that the national authorities had verified whether the applicants' mental disorders persisted. However, their decisions still failed to provide any concrete indication of the degree of danger and whether the applicants were dangerous to themselves or to others (§§ 64 – 65).

- iii. arbitrary deprivations of liberty due to court decisions to maintain psychiatric detention on grounds other than those prescribed by the law and to the non-implementation of decisions to end such detention or replace it with the less severe measure of compulsory outpatient medical treatment (violation of Article 5, paragraph 1 in *N.*).

The Court found that in 2016, in the absence of any legal provision to allow it, the domestic courts provisionally continued the applicant's detention to give time to the social services to organise his transfer to a facility suited to his needs. As this was not done, in 2017 the courts decided to replace the measure of psychiatric detention with that of compulsory treatment and ordered the applicant's release from hospital in conditions suited to his needs. This decision remained unimplemented at the time of the Court's judgment due to the authorities' failure to carry out a rigorous assessment of the applicant's specific needs and of the social welfare measures that would be appropriate, and to the lack of suitable reception facilities (§§ 164 and 167).

Although the applicant had agreed to remain in hospital until a solution could be found, the Court considered that he ought to have been granted adequate safeguards, which should have led to his release without unjustified delay. It stressed that practices which have become quite common at international level in recent years, geared to promoting, as far as possible, treatment and care for persons with disabilities in the community, were relevant to its assessment whether decisions ordering release from psychiatric detention have been effectively implemented (§§ 165 – 166).

- iv. insufficient safeguards against arbitrariness in judicial review proceedings of the necessity to maintain psychiatric detention, due to (i) the failure of the domestic courts to decide speedily and (ii) the lack of effective legal assistance (violation of Article 5, paragraph 4 in *N.*).

The European Court found that neither the duration of the relevant proceedings, which ranged from 15 to 44 months, nor the intervals at which the domestic courts had decided on the need to maintain the detention met the *requirement of speediness*. It considered particularly problematic the practice of the courts to decide based on medical information obtained a long time in advance (for example more than one, two or three years previously), which did not necessarily reflect the condition of the detained person at the time of the decision. While noting that the disciplinary body of the judiciary had attributed this practice to the delay taken by the medical authorities in forwarding their reports, the Court stressed that the domestic courts had failed to take any action to secure their timely submission (§§ 190 – 195).

As regards *legal assistance*, which is mandatory in domestic law in such cases, the Court recalled that an effective legal representation of people with disabilities requires an enhanced duty of supervision of

their representatives by the relevant domestic courts (§ 196).<sup>16</sup> It noted that for the greater part of his detention, the applicant had been represented by a different officially appointed lawyer in each set of proceedings, who either advocated the maintenance of the detention or left it to the discretion of the courts, and that the applicant did not have the opportunity to speak to them before the hearings (§ 197).

- v. lack of minimum legal safeguards against forcible medication of patients subjected to psychiatric detention (violation of Article 8 in *R.D. and I.M.D.*).

The Court found it established that the applicants had to take medication whilst detained and noted the Government's submissions that the provisions in the Mental Health Act regulating consent to psychiatric treatment do not apply to patients subjected to psychiatric detention (§§ 72 and 77).

The Court then rejected the Government's submissions that the criminal law and procedure provisions which establish when and how psychiatric detention can be imposed, maintained, or lifted, provide a sufficient basis for the administration of psychiatric treatment to these patients. It noted that none of these provisions sets out the regime applicable to the effective medical treatment of mental disorder;<sup>17</sup> how these patients' consent must be sought; and the procedure to be followed if they refuse to undergo treatment. It was also not apparent from the legislation that a doctor's decision regarding the medication to be administered can be appealed, therefore these patients have no remedy enabling them to ask a court to rule on the lawfulness of the forcible administration of medicines, including its proportionality, and to order its cessation (§§ 76 and 78).

**Scope and root causes:** The Court considered that the deficiencies identified in these judgments were liable to give rise to further justified applications. Under Article 46 of the Convention, it recommended that Romania envisage general measures to ensure that (i) the detention of individuals in psychiatric hospitals was lawful, justified and not arbitrary (*N.*); (ii) any individuals detained in such institutions are entitled to take proceedings affording adequate safeguards with a view to securing a speedy court decision on the lawfulness of their detention (*N.*); and (iii) the medical treatment of persons subjected to psychiatric detention is attended by minimum safeguards against arbitrariness (*R.D. and I.M.D.*).

The judgments show that some of the violations stem from defective legislation ((i) and (v) above). The Court's findings and the Ombudsperson 2019 Report on human rights compliance in psychiatric hospitals moreover point to systemic failures which account for the practice of maintaining psychiatric detention on grounds other than those prescribed by the law ((iii) above). These are linked to both gaps in the legislation and the incapacity of the mental health care and of the social welfare systems to provide suitable community-based accommodation, support, treatment, and care to these patients after discharge.

The Court has likewise identified systemic problems in the judicial review of the necessity to maintain psychiatric detention ((ii) and (iv) above), linked to recurring deficiencies in the practice of the judicial and of the forensic medical authorities involved in the relevant procedures, and in the legal assistance provided to individuals subjected to such measures by officially appointed lawyers.

These findings of deficiencies at multiple levels call for a particularly rigorous analysis of their underlying causes by the authorities, in order to make sure that adequate and sufficient remedial action is taken.

Such an analysis could include verifying the compatibility of the existing legislation with the relevant Convention standards,<sup>18</sup> including to determine whether legislative change would assist in aligning the domestic practice on these,<sup>19</sup> and reviewing, at the level of all relevant actors, their capacity and the

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<sup>16</sup> Knowing that the relevant proceedings are in any event subject to the inquisitorial principle, which obliges the court to act on its own initiative for the purpose of gathering evidence and properly establishing the facts.

<sup>17</sup> Because they do not regulate the framework within which these patients are to be cared for in psychiatric hospitals; they do not specify who is entitled to decide on the treatment; nor define how the prescribed treatment is to be administered, in particular when the patient does not wish to receive it.

<sup>18</sup> Cf. Recommendation Rec(2004)5 of the Committee of Ministers to member states on the verification of the compatibility of draft laws, existing laws and administrative practice with the standards laid down in the European Convention on Human Rights.

<sup>19</sup> For example, the relevant Criminal Code provisions (Article 110) provide that psychiatric detention can be imposed where the perpetrator of an act stipulated by criminal law is "mentally ill" and "poses a danger to society". These do not seem to sufficiently reflect the Article 5 requirements that such detention can only be imposed and maintained where the mental disorder is of a kind or degree warranting compulsory confinement; the persistence of such a disorder warrants the continued confinement; and less severe measures have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained. Civil society has moreover drawn attention to the fact that these provisions, when

means and tools at their disposal to implement those standards practically and effectively.<sup>20</sup> It could moreover draw on past initiatives to reform the forensic psychiatric system in Romania, and the lines of action pursued in this context,<sup>21</sup> and take also account of the difficulties the forensic medical authorities themselves have reported in properly fulfilling their attributions.<sup>22</sup>

## II. General considerations on the action required to implement the judgments

The elements above show that wide-ranging and multi-faceted measures are required to bring about an adequate and lasting resolution of the problems found in these judgments. The financial provisions needed to back up these are clearly very significant, and this is yet another reason why a strong and enduring commitment, in particular from decision-makers, is called for to ensure compliance with Romania's unconditional obligation under Article 46 of the Convention to abide by these judgments.

In developing lasting solutions, the Romanian authorities can draw on the Ombudsperson's findings and recommendations in its Report on human rights compliance in psychiatric hospitals and in reports it has drawn up following on-site visits in such establishments. The CPT 8<sup>th</sup> General Report on its activities also offers valuable guidance on how this can be achieved.<sup>23</sup> Good practices implemented by other Council of Europe member States, such as those identified by the Council of Europe Bioethics Committee,<sup>24</sup> may likewise inform the authorities' choice of means to implement these judgments.

In the immediate term, urgent action should be taken to alleviate overcrowding, to ensure Convention-compliant material conditions, and to increase staffing in the establishments most critically affected, in order to avert violations of the prohibition of inhuman and degrading treatment such as the one found in *Parascineti*.

In the same perspective, the relevant health care and social welfare authorities, at all appropriate levels, should urgently attend to the situation of those patients who are not or are no longer in need of psychiatric hospitalisation but cannot be discharged for the reasons detailed above. The Court found that such a situation constitutes an arbitrary deprivation of liberty (*N. above*) and Romania has an obligation under Article 46 of the Convention to put an end to similar ongoing human rights violations.

Strengthening the legal safeguards, securing their rigorous and consistent application by relevant medical professionals and by the judiciary, and ensuring effective legal assistance in involuntary placement procedures under the Mental Health Act and under the Criminal Code is moreover required to guarantee non-repetition of other violations of the right to liberty and security established in these cases (*Cristian Teodorăscu and N. groups*).

By ensuring that such placements are implemented in strict compliance with the relevant Convention requirements, such remedial action is also likely to contribute to alleviating overcrowding and to improving the outlook for remaining patients and also for staff, pending the implementation of lasting solutions to the structural problems affecting the existing mental health care system and psychiatric establishments.

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applied to people with intellectual disabilities, may lead to lifelong detentions, since these people are unlikely to ever meet the legal conditions set for release (recovery or improvement in their condition) (see DH-DD(2023)546).

<sup>20</sup> The authorities outlined in their latest submissions (DH-DD(2023)354-rev) initiatives to provide interdisciplinary training to relevant professionals. While these may well go into the right direction, it is for the authorities to show on which basis they have determined that such measures are adequate and sufficient, in content and scope, to guarantee non-repetition of the violations.

<sup>21</sup> Details are included in the Rule 9 (2) submissions received in 2018 from the Association for the support of children with special needs « Dr. Katz », the Estuar Foundation and the European Network on Independent Living (DH-DD(2018)1196).

<sup>22</sup> The existing legal framework confers on forensic medicine institutes – which are public institutions listed exhaustively in the relevant legislative acts – an exclusive competence to draw up findings, carry out expert reports or issue forensic opinions that may be used as evidence before national courts, including in proceedings to decide on and prolong psychiatric detention. The most recent activity report published by the National Forensic Institute (for the year 2019) highlighted among other things, that these institutes were facing serious staff shortages, compared to the volume of activity they needed to process. It also indicated that their co-operation with the judicial authorities was made difficult because the latter are insufficiently acquainted with the specifics of the forensic medical activity (the report is available in Romanian at [www.inml-mm.ro](http://www.inml-mm.ro)).

<sup>23</sup> The CPT highlighted the tendency in a number of countries to reduce the number of beds in large psychiatric establishments and to develop community-based mental health units. It found this to be a very favourable development, on condition that such units provide a satisfactory quality of care. It cautioned against the significant risk of institutionalisation for both patients and staff large psychiatric establishments pose, more so if they are situated in isolated locations. It observed that care programmes drawing on the full range of psychiatric treatment are much easier to implement in small units located close to the main urban centres.

<sup>24</sup> See Compendium Report of Good Practices in the Council of Europe Member States to promote Voluntary Measures in Mental Health, commissioned by the Committee on Bioethics (now Steering Committee).

Urgent action should also be taken to address the violations found in relation to the forcible administration of psychiatric treatment to those subjected to involuntary placements.

The deficiencies revealed in the relevant judgments call for a fundamental shift in the legal and practical approach of the question of these patients' consent to such treatment and for measures to ensure that the new, Convention-compliant approach is rigorously and consistently followed by all relevant medical and judicial authorities.

The Court has provided in its latest judgment (*R.D. and I.M.D.*) detailed indications on the aspects to be regulated and the safeguards to be introduced in domestic law. The authorities must therefore draw on these and define and implement rapidly the legislative changes required to put an end to and guarantee non-repetition of the violations for both categories of involuntary patients when it comes to their consent to psychiatric treatment and their protection against forcible administration of such treatment.

In the meantime, the Ministry of Health must urgently take action to ensure that in practice both categories of patients are placed in a position to give their free and informed consent to psychiatric treatment, for example by issuing guidelines to the relevant medical professionals.

The Department for the Execution of Judgments remains at the authorities' disposal to provide any further support they may deem useful in their action to implement these judgments.

Parascineti (cererea nr. 32060/05), grupul Cristian Teodorescu (cererea nr. 22883/05) și  
Grupul N. (Cererea nr. 59152/08) împotriva României

Analiza măsurilor generale

Memorandum elaborat de Departamentul pentru executarea hotărârilor Curții Europene a  
Drepturilor Omului

I. Prezentare generală a aspectelor luate în considerare

A. Aspecte examinate în cauza *Parascineti* (hotărâre definitivă la 13 iunie 2012)

**Probleme:** În această cauză, Curtea Europeană a Drepturilor Omului (Curtea/CEDO) a constatat o încălcare a interdicției tratamentelor inumane și degradante (articolul 3) în timpul plasamentului involuntar al reclamantului în unitatea de psihiatrie a Spitalului Sighetu Marmăției în iulie 2005, din cauza supraaglomerării, a condițiilor sanitare și de igienă precare, inclusiv a lipsei unui pat individual, și a imposibilității de a petrece timp în aer liber din cauza lipsei de personal.

**Domeniul de aplicare, persistența încălcărilor și cauzele profunde:** Încă din primele etape ale procesului de execuție, Comitetul Miniștrilor și-a format opinia că probleme similare afectau într-o anumită măsură multe dintre unitățile de psihiatrie din România. Acest lucru a fost evidențiat, printre altele, de rapoartele Comitetului European pentru Prevenirea Torturii (CPT) și ale Avocatului Poporului din România, inclusiv prin Mecanismul Național de Prevenire, care au furnizat, de asemenea, indicații cu privire la cauzele profunde ale unor astfel de deficiențe și la măsurile necesare pentru a le remedia.

Mai recent, un Raport al Avocatului Poporului privind respectarea drepturilor omului în spitalele de psihiatrie din România, publicat în noiembrie 2019 („Raportul”), a constatat că:

- *supraaglomerarea este încă o problemă în multe spitale de psihiatrie*, în special în cele care sunt autorizate să aplice detenția psihiatrică și în spitalele pentru pacienți cronici.

Ca factori de bază, raportul evidențiază presiunea mare asupra spitalelor de psihiatrie de a interna pacienți, pe fondul unei lipse acute de servicii de sănătate mintală în comunitate. Raportul constată că unele spitale, care funcționează deja peste capacitate, au liste de așteptare și constată, de asemenea, o creștere a numărului de pacienți supuși detenției psihiatrice (a se vedea, de asemenea, grupul N. de mai jos). Recomandă Ministerului Sănătății să elaboreze un plan de măsuri urgente pentru a combate supraaglomerarea în spitalele/unitățile de psihiatrie și pentru a asigura respectarea standardelor generale de cazare a pacienților în spitalele din România.

Raportul aduce în continuare în atenție situația pacienților denumiți „cazuri sociale”, adică a celor care pot fi externați, dar care au pierdut legăturile cu familia și comunitatea și au nevoie de aranjamente alternative care să le permită să primească îngrijire și sprijin medical și social adecvat în comunitate; mulți dintre acești pacienți se află de mult timp în spitalul de psihiatrie.

Acesta constată că există în continuare cazuri în care instanțele mențin detenția psihiatrică fără a fi necesară din punct de vedere medical, deoarece pacienții nu pot beneficia de sprijin ambulatoriu și de monitorizare, inclusiv pentru a se asigura că vor urma un tratament medical obligatoriu pe care instanțele îl pot impune ca o condiție pentru eliberarea lor (a se vedea, de asemenea, grupul N. de mai jos). În alte rapoarte întocmite în urma vizitelor la fața locului, Avocatul Poporului a observat că persoanele cu dizabilități intelectuale sunt plasate sau transferate la spitalul de psihiatrie de la unitățile de asistență socială pentru șederi prelungite, chiar dacă aceste spitale nu sunt unități adecvate pentru îngrijirea acestor persoane.

Raportul constată că măsurile luate de spitale pentru a ține legătura cu autoritățile de asistență socială nu au dat rezultate și subliniază lipsa de interes real pentru a găsi soluții pentru acești pacienți. Raportul recomandă ca Ministerul Sănătății să identifice, împreună cu alte autorități publice și părți interesate relevante, soluții care să permită reintegrarea acestor persoane în comunitate. La nivel legislativ, solicită completarea legislației privind sănătatea mintală cu prevederi referitoare la dezinstituționalizarea pacienților care nu mai necesită spitalizare și la măsuri de îngrijire multidisciplinară (medicală și socială), integrată și interinstituțională și de monitorizare în comunitate.

*- condițiile materiale rămân în general problematice*

Raportul constată că, cu unele excepții, condițiile oferite pacienților sunt nesatisfăcătoare: spațiul de locuit este insuficient, saloanele sunt în stare proastă de întreținere, instalațiile sanitare sunt degradate și insuficiente având în vedere numărul de pacienți, iar infrastructura este inadecvată pentru ca unele dintre aceste spitale să desfășoare activitățile în conformitate cu standardele relevante și în condiții de siguranță pentru pacienți. Recomandă Ministerului Sănătății să ia în considerare lucrări de reabilitare în unitățile aflate în responsabilitatea sa, care se află într-o stare avansată de degradare.

*- spitalele de psihiatrie continuă să se confrunte cu grave lipsuri de personal*

Raportul analizează situația în ceea ce privește medicii, asistentele, asistenții medicali și îngrijitorii (inclusiv personalul responsabil cu supravegherea pacienților). Acesta constată probleme legate de posturile vacante neocupate, în special în cazul medicilor, și subliniază alte câteva probleme sistematice în legătură cu statutul, nivelurile și formarea personalului de supraveghere și consecințele grave pe care acestea le au asupra siguranței pacienților și a personalului și asupra respectării drepturilor omului în ceea ce privește modul în care sunt tratați pacienții. De asemenea, consideră că normele generale privind personalul spitalicesc sunt inadecvate pentru spitalele de psihiatrie și ar trebui adaptate prin creșterea numărului de posturi alocate acestor spitale.

Raportul nu abordează în detaliu situația altor categorii de personal, cum ar fi psihologii, terapeuții și asistenții sociali, care, prin lege, ar trebui să facă parte din echipele terapeutice care se ocupă de pacienți. Acesta observă totuși că, într-un spital, lipsa unui astfel de personal specializat a însemnat că pacienții nu au putut beneficia de terapii adecvate și de activități semnificative.

Raportul recomandă măsuri legislative, politice, de consolidare a capacităților și alte măsuri practice pentru a remedia aceste deficiențe, inclusiv pentru a suplini posturile vacante existente și pentru a asigura pacienților din astfel de spitale o îngrijire terapeutică individualizată și adecvată.

*- finanțarea spitalelor de psihiatrie*

Raportul indică faptul că cele patru spitale autorizate să implementeze detenția psihiatrică se află sub responsabilitatea Ministerului Sănătății, iar celelalte spitale sub cea a consiliilor județene sau a consiliilor locale. Raportul recomandă Ministerului Sănătății să aibă în vedere transferul acestor ultime spitale în responsabilitatea consiliilor județene, pentru o mai bună finanțare, și să identifice noi mijloace de susținere financiară a sistemului de sănătate mintală, inclusiv prin programe naționale sau prin proiecte care să atragă fonduri dedicate. De asemenea, face recomandări specifice pentru finanțarea celor patru spitale securizate, și anume ca o parte din costurile operaționale ale acestora să fie preluate de Ministerul Justiției.

În observațiile sale finale, raportul își exprimă îngrijorarea cu privire la condițiile în care trăiesc pacienții și în care lucrează personalul în unele dintre aceste spitale; formarea insuficientă a personalului pentru o abordare echilibrată între sarcina de supraveghere a pacienților și imperativul respectării drepturilor lor fundamentale; cadrul legal inadecvat privind personalul și formarea profesională în raport cu nevoile specifice din sistemul de sănătate mintală; faptul că terapiile alternative, care ar trebui să sprijine recuperarea pacienților, sunt practic inexistente în aceste spitale, iar pacienților nu li se oferă un sistem coerent de monitorizare a sănătății mintale, inclusiv după externare. Raportul concluzionează că aceste aspecte provin dintr-un sistem de sănătate mintală învechit, care permite în continuare maltratarea pacienților și practicile abuzive de constrângere și are nevoie de noi politici publice și de prevederi bugetare adecvate pentru a le pune în aplicare.

**B. Aspecte examinate în grupul *Cristian Teodorescu* (hotărâri definitive la 19 septembrie 2012 și 16 decembrie 2014)**

**Probleme:** Cauzele din acest grup se referă la încălcări ale dreptului la libertate și siguranță (articolul 5) și ale dreptului la integritate fizică și morală (articolul 8), în legătură cu plasamentele involuntare puse în aplicare ca măsuri de protecție în temeiul *Legii privind sănătatea mintală* și cu tratamentul medical al acestor pacienți.

Curtea a constatat că reclamanții au fost plasați într-un spital de psihiatrie (sau arestați de poliție în vederea unui astfel de plasament) fără respectarea procedurii prevăzute de *Legea privind sănătatea mintală* și fără nicio justificare legată de starea lor de sănătate mintală.

Într-una dintre cauze (*Atudorei*), Curtea a constatat, de asemenea, că psihiatrul care a asistat-o pe reclamantă nu a respectat cerința legală de a obține consimțământul acesteia cu privire la tratamentul medical furnizat în timpul plasamentului său sau, în absența unui astfel de

consimțământ, de a supune acest tratament spre validare unei comisii medicale, așa cum prevăd dispozițiile relevante ale *Legii privind sănătatea mintală*.

Curtea a observat că aceste încălcări au avut loc în contextul unor deficiențe ale dispozițiilor care reglementează procedura și garanțiile în domeniul plasamentului involuntar la momentul respectiv (2004-2008), precum și al unor probleme mai generale care au afectat aplicarea *Legii privind sănătatea mintală*. CEDO a subliniat că eșecul Ministerului Sănătății de a desemna spitalele autorizate să procedeze la plasamente involuntare, împreună cu o cunoaștere lacunară în rândul personalului medical a procedurilor prevăzute de această lege, ceea ce a făcut ca aplicarea acesteia să fie dificilă și inconsecventă (*Atudorei*, §§ 85-87 și 149).

**Domeniul de aplicare, persistența încălcărilor și cauzele principale:** Comitetul Miniștrilor a concluzionat că modificările aduse *Legii privind sănătatea mintală* în 2012 au corectat deficiențele legislative identificate de Curte în ceea ce privește procedura și garanțiile care participă la plasamentele involuntare. În același timp, Comitetul Miniștrilor a observat că, deși aceste modificări au supus deciziile inițiale de plasament la o revizuire judiciară din oficiu, nu a fost prevăzută o astfel de revizuire în ceea ce privește deciziile de reînnoire a plasamentelor involuntare, care sunt lăsate în întregime la latitudinea comisiilor spitalicești relevante. Îngrijorat de faptul că acest lucru ar putea duce la reînnoirea nejustificată a unor astfel de plasamente și, astfel, la agravarea supraaglomerării în spitalele de psihiatrie, CM a solicitat autorităților să completeze această lacună. Această solicitare a rămas până în prezent fără răspuns.

În ceea ce privește neaplicarea de către profesioniștii din domeniul sănătății mintale relevanți a procedurii de plasament nevoluntar, CM a constatat că această problemă a rămas nerezolvată. Acesta s-a bazat pe rapoartele Avocatului Poporului care evidențiază nu numai deficiențe în aplicarea procedurii legale și a garanțiilor, ci și situații în care dispozițiile legale relevante par să fi fost eludate, iar pacienții au fost supuși de facto plasamentelor involuntare. Rapoartele au evidențiat, de asemenea, probleme în cadrul procedurilor de revizuire judiciară a deciziilor inițiale de plasament, ceea ce a determinat Avocatul Poporului să recomande noi modificări ale *Legii privind sănătatea mintală*, exprimându-și totodată îngrijorarea că autoritățile medicale și judiciare competente să decidă, să valideze și să revizuiască astfel de plasamente nu par să aprecieze pe deplin faptul că acestea reprezintă privări de libertate.

În Raportul său din 2019 privind respectarea drepturilor omului în spitalele de psihiatrie, Avocatul Poporului a observat, de asemenea, că Ministerul Sănătății nu a respectat încă reglementările existente care îi impun să desemneze spitalele autorizate să procedeze la plasamente involuntare. Acesta și-a exprimat din acest motiv îngrijorarea cu privire la legalitatea oricărui astfel de plasamente puse în aplicare în temeiul *Legii privind sănătatea mintală*.

Autoritățile române nu au abordat niciodată, în observațiile lor către Comitetul Miniștrilor, încălcarea articolului 8 constatată din cauza nerespectării de către psihiatri a dispozițiilor și garanțiilor privind consimțământul la tratamentul psihiatric, deși rapoartele Avocatului Poporului au continuat să arate că acestea nu erau încă aplicate în mod consecvent. La rândul său, CPT a constatat în timpul vizitei sale din 2014, pe fondul unor neconcordanțe în reglementările de punere în aplicare a *Legii privind sănătatea mintală*, că personalul medical nu a solicitat

consimțământul pentru tratament separat de consimțământul pentru plasament. Atunci când era vorba de pacienți supuși plasamentelor involuntare, se înțelegea că decizia de plasament îi exonerează pe psihiatri de obligația de a solicita consimțământul acestor pacienți pentru tratamentul psihiatric.

## **B. Aspecte examinate în cauzele *N.* și *R.D.* și *I.M.D.* (hotărâri definitive la 28 februarie 2018 și 12 octombrie 2021)**

**Probleme:** Aceste cauze se referă la încălcări ale dreptului la libertate și la siguranță (articolul 5) și ale dreptului la integritate fizică și morală (articolul 8), în legătură cu detenția și tratamentul psihiatric impuse ca măsuri de siguranță în temeiul Codului penal, fie direct (*N.*), fie ca urmare a nerespectării de către o persoană a unei hotărâri judecătorești anterioare care îi impunea obligația de a urma un tratament medical ambulatoriu pentru o tulburare mintală diagnosticată (*R.D.* și *I.M.D.*).

### **Detalii și contextul încălcărilor:**

i. insuficiența garantiilor juridice care însoțesc detenția psihiatrică a persoanelor care nu se conformează ordinelor judecătorești care le impun obligația de a urma un tratament psihiatric ambulatoriu (încălcarea articolului 5 alineatul (1) în *R.D.* și *I.M.D.*).

Curtea a constatat că această încălcare își are rădăcinile în legislație (§ 62). Într-adevăr, în astfel de cazuri, dispozițiile relevante (articolul 568 § 1 din Codul de procedură penală) impun instanțelor să impună detenția fără a beneficia de o examinare de specialitate recentă și fără a le permite să verifice pe această bază dacă tulburarea mentală persistă și este de un tip sau de un grad care justifică detenția psihiatrică.

ii. detenție psihiatrică ilegală din cauza faptului că instanțele relevante nu au evaluat și nu au justificat necesitatea de a prelungi astfel de măsuri pe baza gravității stării psihiatrice a pacienților și a riscului pe care aceasta îl reprezintă pentru ei înșiși sau pentru alte persoane, și nu au luat în considerare dacă măsuri mai puțin severe ar fi suficiente pentru a contracara un astfel de risc (încălcarea articolului 5 alineatul (1) în cazul *N.*).

În cauza *N.*, Curtea a constatat că privarea de libertate a reclamantului între 2007 și 2016 a fost lipsită de temei juridic, în principal pentru că instanțele naționale nu au evaluat pericolul pe care acesta îl reprezenta pentru societate, care este un element esențial în dreptul intern, ci s-au bazat doar pe rapoartele medico-legale care atestau că acesta avea o afecțiune psihiatrică. Nici autoritățile medicale, nici instanțele nu au luat în considerare dacă în cazul său ar fi putut fi aplicate măsuri alternative. Pe lângă faptul că a fost contrară dreptului intern și articolului 5 § 1, detenția a fost în contradicție cu principiul conform căruia simpla existență a unui handicap nu justifică în niciun caz o privare de libertate, stabilit în Convenția Organizației Națiunilor Unite privind drepturile persoanelor cu handicap (§§ 154 - 159).

În cazul *R.D.* și *I.M.D.*, deși încălcarea se referă doar la ordinul inițial de detenție (mai sus), Curtea a observat că examinările psihiatrice medico-legale efectuate în anii imediat următori

acestui ordin au fost foarte sumare, au conținut informații insuficiente privind raționamentul medical și examinările clinice efectuate și nu au stabilit că reclamanții erau periculoși pentru ei înșiși sau pentru societate. Începând cu 2018, rapoartele de expertiză au devenit mult mai detaliate, iar hotărârile judecătorești au motivat cu precizie necesitatea menținerii detenției. Rapoartele medico-legale și hotărârile judecătorești au arătat că autoritățile naționale au verificat dacă tulburările psihice ale reclamanților persistau. Cu toate acestea, deciziile lor încă nu au reușit să ofere nicio indicație concretă cu privire la gradul de pericol și dacă reclamanții erau periculoși pentru ei înșiși sau pentru alții (§§ 64 - 65).

iii. privarea arbitrară de libertate din cauza hotărârilor judecătorești de menținere a detenției psihiatrice din alte motive decât cele prevăzute de lege și a neexecutării hotărârilor de încetare a unei astfel de detenții sau de înlocuire a acesteia cu măsura mai puțin severă a tratamentului medical obligatoriu în ambulatoriu (încălcarea articolului 5, alineatul 1 în *N.*).

Curtea a constatat că, în 2016, în absența oricărei dispoziții legale care să permită acest lucru, instanțele interne au continuat provizoriu detenția reclamantului pentru a da timp serviciilor sociale să organizeze transferul acestuia într-un centru adaptat nevoilor sale. Întrucât acest lucru nu a fost făcut, în 2017, instanțele au decis să înlocuiască măsura detenției psihiatrice cu cea a tratamentului obligatoriu și au dispus eliberarea reclamantului din spital în condiții adaptate nevoilor sale. Această decizie a rămas neexecutată la momentul pronunțării hotărârii Curții din cauza faptului că autoritățile nu au efectuat o evaluare riguroasă a nevoilor specifice ale reclamantului și a măsurilor de asistență socială care ar fi fost adecvate, precum și din cauza lipsei unor facilități de primire adecvate (§§ 164 și 167).

Deși reclamantul a fost de acord să rămână în spital până la găsirea unei soluții, Curtea a considerat că ar fi trebuit să i se acorde garanții adecvate, care ar fi trebuit să conducă la eliberarea sa fără întârzieri nejustificate. Curtea a subliniat că practicile care au devenit destul de comune la nivel internațional în ultimii ani, orientate spre promovarea, pe cât posibil, a tratamentului și îngrijirii persoanelor cu dizabilități în cadrul comunității, erau relevante pentru a evalua dacă deciziile care dispuneau eliberarea din detenția psihiatrică au fost puse în aplicare în mod efectiv (§§ 165 - 166).

iv. garanții insuficiente împotriva arbitrariului în procedurile de control judiciar al necesității de a menține detenția psihiatrică, din cauza (i) eșecului instanțelor interne de a decide rapid și (ii) lipsei unei asistențe juridice efective (încălcarea articolului 5, alineatul 4 din *N.*).

Curtea a constatat că nici durata procedurilor relevante, care a variat de la 15 la 44 de luni, nici intervalele la care instanțele naționale au decis cu privire la necesitatea menținerii detenției nu au îndeplinit cerința de celeritate. Aceasta a considerat deosebit de problematică practica instanțelor de a decide pe baza unor informații medicale obținute cu mult timp înainte (de exemplu, cu mai mult de unul, doi sau trei ani înainte), care nu reflectau în mod necesar starea persoanei reținute la momentul luării deciziei. Deși a remarcat că organul disciplinar al sistemului judiciar a atribuit această practică întârzierii cu care autoritățile medicale au transmis rapoartele lor, Curtea a subliniat că instanțele naționale nu au luat nicio măsură pentru a asigura prezentarea lor la timp (§§ 190 - 195).

În ceea ce privește asistența juridică, care este obligatorie în dreptul intern în astfel de cazuri, Curtea a reamintit că o reprezentare juridică efectivă a persoanelor cu dizabilități necesită o obligație sporită de supraveghere a reprezentanților acestora de către instanțele interne relevante (§ 196). Aceasta a notat că, în cea mai mare parte a detenției sale, reclamantul a fost reprezentat de un avocat desemnat oficial diferit în fiecare serie de proceduri, care fie a pledat pentru menținerea detenției, fie a lăsat-o la discreția instanțelor, și că reclamantul nu a avut posibilitatea de a vorbi cu aceștia înainte de audieri (§ 197).

v. lipsa unor garanții legale minime împotriva medicației forțate a pacienților supuși detenției psihiatrice (încălcarea articolului 8 în cazul R.D. și I.M.D.).

Curtea a constatat că a fost stabilit faptul că reclamantii trebuiau să ia medicamente în timpul detenției și a luat act de afirmațiile Guvernului potrivit cărora dispozițiile din *Legea privind sănătatea mintală* care reglementează consimțământul la tratamentul psihiatric nu se aplică pacienților supuși detenției psihiatrice (§§ 72 și 77).

Apoi, Curtea a respins argumentele Guvernului potrivit cărora dispozițiile de drept penal și de procedură penală care stabilesc când și cum poate fi impusă, menținută sau ridicată detenția psihiatrică, oferă o bază suficientă pentru administrarea tratamentului psihiatric acestor pacienți. Aceasta a observat că niciuna dintre aceste dispoziții nu stabilește regimul aplicabil tratamentului medical eficient al tulburărilor psihice, modul în care trebuie să se obțină consimțământul acestor pacienți și procedura care trebuie urmată în cazul în care aceștia refuză să se supună tratamentului. De asemenea, din legislație nu reiese că decizia medicului cu privire la medicația care urmează să fie administrată poate fi atacată, prin urmare acești pacienți nu dispun de nicio cale de atac care să le permită să ceară unei instanțe să se pronunțe asupra legalității administrării forțate de medicamente, inclusiv asupra proporționalității acesteia, și să dispună încetarea acesteia (§§ 76 și 78).

**Domeniul de aplicare și cauzele principale:** Curtea a considerat că deficiențele identificate în aceste hotărâri sunt susceptibile de a da naștere la alte cereri justificate. În temeiul articolului 46 din Convenție, aceasta a recomandat României să prevadă măsuri generale pentru a se asigura că (i) detenția persoanelor în spitalele de psihiatrie este legală, justificată și nu arbitrară (N.); (ii) orice persoană reținută în astfel de instituții are dreptul de a introduce o acțiune în justiție care să ofere garanții adecvate în vederea obținerii unei hotărâri judecătorești rapide cu privire la legalitatea detenției lor (N.); și (iii) tratamentul medical al persoanelor supuse detenției psihiatrice este însoțit de garanții minime împotriva arbitrariului (R.D. și I.M.D.).

Hotărârile arată că unele dintre încălcări rezultă din legislația defectuoasă ((i) și (v) de mai sus). Constatările Curții și Raportul Avocatului Poporului din 2019 privind respectarea drepturilor omului în spitalele de psihiatrie indică, în plus, deficiențe sistemice care explică practica menținerii detenției psihiatrice din alte motive decât cele prevăzute de lege ((iii) de mai sus). Acestea sunt legate atât de lacunele din legislație, cât și de incapacitatea sistemului de asistență medicală mentală și a sistemului de asistență socială de a oferi cazare, sprijin, tratament și îngrijire adecvate în comunitate acestor pacienți după externare.

De asemenea, Curtea a identificat probleme sistemice în cadrul controlului judiciar al necesității de a menține detenția psihiatrică ((ii) și (iv) de mai sus), legate de deficiențe recurente în practica autorităților judiciare și a autorităților medico-legale implicate în procedurile relevante, precum și în asistența juridică oferită persoanelor supuse unor astfel de măsuri de către avocații desemnați oficial.

Aceste constatări de deficiențe la mai multe niveluri necesită o analiză deosebit de riguroasă a cauzelor care stau la baza acestora de către autorități, pentru a se asigura că se iau măsuri de remediere adecvate și suficiente.

O astfel de analiză ar putea include verificarea compatibilității legislației existente cu standardele relevante ale Convenției, inclusiv pentru a determina dacă o modificare legislativă ar contribui la alinierea practicii naționale la acestea, precum și examinarea, la nivelul tuturor actorilor relevanți, a capacității acestora și a mijloacelor și instrumentelor de care dispun pentru a pune în aplicare aceste standarde în mod practic și eficient. În plus, ar putea să se bazeze pe inițiativele anterioare de reformare a sistemului de psihiatrie medico-legală din România și pe liniile de acțiune urmărite în acest context și să ia în considerare, de asemenea, dificultățile pe care autoritățile medicale medico-legale însele le-au semnalat în ceea ce privește îndeplinirea corespunzătoare a atribuțiilor lor.

## **II. Considerații generale privind acțiunile necesare pentru punerea în aplicare a hotărârilor**

Elementele de mai sus arată că sunt necesare măsuri de amploare și cu multiple fațete pentru a se ajunge la o rezolvare adecvată și durabilă a problemelor constatate în aceste hotărâri. Prevederile financiare necesare pentru a le susține sunt în mod clar foarte semnificative, iar acesta este încă un motiv în plus pentru care este necesar un angajament puternic și durabil, în special din partea factorilor de decizie, pentru a asigura respectarea obligației necondiționate a României, în temeiul articolului 46 din Convenție, de a respecta aceste hotărâri.

În elaborarea unor soluții durabile, autoritățile române se pot baza pe constatările și recomandările Avocatului Poporului din în Raportul său privind respectarea drepturilor omului în spitalele de psihiatrie și în rapoartele pe care le-a întocmit în urma vizitelor la fața locului în astfel de unități. Cel de-al 8-lea Raport general al CPT privind activitățile sale oferă, de asemenea, orientări valoroase cu privire la modul în care se poate realiza acest lucru. Bunele practici puse în aplicare de alte state membre ale Consiliului Europei, cum ar fi cele identificate de Comitetul de Bioetică al Consiliului Europei, pot, de asemenea, să informeze autoritățile cu privire la alegerea mijloacelor de punere în aplicare a acestor hotărâri.

Pe termen scurt, ar trebui să se ia măsuri urgente pentru a atenua supraaglomerarea, pentru a asigura condiții materiale conforme cu Convenția și pentru a crește personalul în unitățile cele mai grav afectate, pentru a evita încălcări ale interdicției tratamentelor inumane și degradante, precum cea constatată la *Parascineti*.

Din aceeași perspectivă, autoritățile competente din domeniul sănătății și al asistenței sociale, la toate nivelurile corespunzătoare, ar trebui să se ocupe de urgență de situația acelor pacienți care nu au sau nu mai au nevoie de spitalizare psihiatrică, dar care nu pot fi externați din motivele detaliate mai sus. Curtea a constatat că o astfel de situație constituie o privare arbitrară de libertate (*N.* de mai sus), iar România are obligația, în temeiul articolului 46 din Convenție, de a pune capăt unor încălcări similare ale drepturilor omului aflate în curs de desfășurare.

Consolidarea garanțiilor legale, asigurarea aplicării lor riguroase și consecvente de către cadrele medicale relevante și de către sistemul judiciar, precum și asigurarea unei asistențe juridice efective în procedurile de plasament involuntar în temeiul *Legii privind sănătatea mintală* și al Codului penal sunt, în plus, necesare pentru a garanta nerepetarea altor încălcări ale dreptului la libertate și siguranță stabilite în aceste cazuri (grupurile *Cristian Teodorescu* și *N.*).

Prin asigurarea faptului că astfel de plasamente sunt puse în aplicare în strictă conformitate cu cerințele relevante ale Convenției, o astfel de măsură de remediere poate contribui, de asemenea, la reducerea supraaglomerării și la îmbunătățirea perspectivelor pentru pacienții rămași și pentru personal, până la punerea în aplicare a unor soluții durabile la problemele structurale care afectează sistemul de îngrijire a sănătății mintale și unitățile de psihiatrie existente.

Ar trebui, de asemenea, să se ia măsuri urgente pentru a aborda încălcările constatate în legătură cu administrarea forțată a tratamentului psihiatric celor supuși plasamentelor involuntare.

Deficiențele evidențiate în hotărârile relevante impun o schimbare fundamentală în abordarea juridică și practică a chestiunii privind consimțământul acestor pacienți la un astfel de tratament și măsuri care să asigure că noua abordare, conformă cu Convenția, este urmată în mod riguros și consecvent de toate autoritățile medicale și judiciare relevante.

În ultima sa hotărâre (*R.D. și I.M.D.*), Curtea a oferit indicații detaliate cu privire la aspectele care trebuie reglementate și la garanțiile care trebuie introduse în dreptul intern. Prin urmare, autoritățile trebuie să se bazeze pe acestea și să definească și să pună în aplicare rapid modificările legislative necesare pentru a pune capăt și a garanta nerepetarea încălcărilor pentru ambele categorii de pacienți involuntari în ceea ce privește consimțământul acestora la tratamentul psihiatric și protecția lor împotriva administrării forțate a unui astfel de tratament.

Între timp, Ministerul Sănătății trebuie să acționeze de urgență pentru a se asigura că, în practică, ambele categorii de pacienți sunt puse în situația de a-și da consimțământul liber și în cunoștință de cauză la tratamentul psihiatric, de exemplu prin emiterea de orientări pentru cadrele medicale relevante.

Departamentul pentru Executarea Hotărârilor CEDO rămâne la dispoziția autorităților pentru a oferi orice sprijin suplimentar pe care acestea îl vor considera util în acțiunea lor de punere în aplicare a acestor hotărâri.