Report on the Inquiry into the Conditions of Protective Treatment of Mr. A. A. in Psychiatric Hospital A (shortened and anonymized)

In his letter of 20 May 2016, Mr. A. A. (hereinafter also the "patient") complained to me about the conditions to which he was being subjected within the protective (forensic) treatment in Psychiatric Hospital A, XXXXXXXXXXXXX. The contents of Mr A.'s claim need not be protected as his complaints have been known (not only) to the hospital for some time. He complained about the conditions in which he was being held in ward X: room with an armoured door, bars, cameras, dangerous fellow patients; the imposed regime, being separated from people, body searches, ban on smoking, supervision during phone calls, impossibility of leaving the hospital; bad relationships with the hospital staff, in particular the head doctor. When assessing his situation, the patient used words like "tyranny" and "cruelty". He also asked for the form of his treatment to be transformed into out-patient treatment and for a re-evaluation of his diagnosis. Mr A. had made complaints before, in the hospital and with the court, and had also filed a criminal complaint.

A. Subject and result of the inquiry

I focused on issues within my competence as stipulated by the Public Defender of Rights Act.[1] These issues specifically include the conditions in ward X and the reason for holding Mr A. in this ward, the regime to which he is subjected and handling of his complaints. On the other hand, I refrained from making any decisions on the protective treatment itself and diagnosis, as I am not competent to assess these.

In order to ascertain the facts of the case, I ordered an on-site inquiry in the hospital on 13 June 2016. Within this inquiry, the authorised Office employees obtained statements from the patient, head doctor MUDr. B. B., member of the hospital management MUDr. C. C., who currently works as a medical treatment expert and personally intervened in Mr A.'s case, and briefly talked with the nursing staff; they looked into the conditions in wards X and Y; they studied, made extracts from and copies of medical records, and obtained further documents. I also requested a written statement from Mr A.'s mother, MUDr. D. D., who is his legal representative (guardian); from the Police body regarding the procedure following Mr A.'s criminal complaint; and from the hospital in order to obtain further documents. I also notified the court of my inquiry.

My findings are included in part B of this Report and the results of my thorough assessment of the matter can be found in part C.

- I reached the conclusion that Psychiatric Hospital A erred by (i) subjecting its protective-treatment patient to ill-treatment[2] consisting in holding him unlawfully

1 Act No. 349/1999 Coll., on the Public Defender of Rights, as amended

2 In this report, I use the word "ill-treatment" in the sense of "inhuman or degrading treatment or punishment", which is prohibited by Art. 7 (2) of the Charter of Fundamental Rights and Freedoms and Article 3 of the Convention for the Protection of Human Rights and Fundamental Freedoms.

in an isolation room for the periods of 10, 13 and 7 days and holding him for months under an unacceptably strict regime; (ii) the decision to place him in the isolation room was made by the nursing staff (not the doctor) in a situation with no risk of delay; (iii) the hospital failed to properly handle the complaints of the patient and his guardian.

- I have also identified errors in the conditions in ward X, which do not achieve a standard of therapeutic environment suitable for a long-term stay, and in the lack of systematic internal control of using restraints and long-term holding under the admission-bedroom regime.

In cases of ill-treatment, remedial measures need to be taken without delay. I await the response of the psychiatric hospital and I am ready to participate in a dialogue with other actors as well, such as the court.

B. Findings of fact

B.1 Regarding the protective treatment of Mr A. and the related decision-making

Institutional protective treatment was ordered by the court[3] to Mr A. in 1994; its duration is subject to assessment by the District Court in P. The current decision on its prolongation by two years was made in autumn 2015. According to an expert's opinion, the protective treatment of the patient has mainly detention purposes. Staying outside the institutional facility bears a significant risk of deterioration of Mr A.'s medical condition and the related antisocial behaviour. So far, the institutional protective treatment has not met its objective and it is still socially dangerous to let the patient stay outside the facility.

Within this 2015 periodic review, the State Attorney applied for transfer from protective treatment to preventive detention; when the court refused her application, she lodged a complaint against the resolution issued by the first-instance court. From the State Attorney's point of view, the patient repeatedly and substantially violated the treatment regime, manifesting thereby his negative approach towards protective treatment. She insisted that the expert's findings, i.e. that the patient had a non-critical attitude towards his abuse of alcohol and psychoactive drugs and tried to obtain these, had to be judged in the context of the fact that the patient last intoxicated himself in summer 2015 and that in September he repeatedly kicked the door of the staff room. The appellate court rejected the complaint, coming to the conclusion that the failures of the assessed person (violation of regime) were reduced in 2015 and they did not constitute deviations from what corresponded to the serious diagnosis of the assessed person. To the contrary, his failures confirm the necessity of protective treatment.

At the time of my inquiry, the court was holding another set of proceedings, specifically on Mr A.'s application for transfer to out-patient treatment. However, Mr A. withdrew his application, the ordered public hearing was cancelled and the proceedings were discontinued.

3 based on conduct that would qualify as a particularly serious crime in case of a criminally liable person; the prosecution of Mr A. was terminated on the grounds of insanity

The hospital recently informed me that, in the case of Mr A., the hospital had not filed any applications for transformation of protective treatment and that it also had not internally prepared any application for transfer to preventive detention. I accept this information; however, it is also clear that the therapeutic team has been considering the application for transfer to preventive detention since November 2015, as described below.

B.2 Regarding Mr A.

The legal capacity of Mr A. has been restricted for years. Following a review, the court issued a judgment on 18 January 2016, setting out specific limitations to Mr A.'s right to dispose of assets and be bound by his legal acts, and determining in what matters he was not able to make legal acts at all. According to the judgment, Mr A. is, among others, "unable to assess the provision of medical services, or the consequences of their provision". The court again appointed his mother, MUDr. D. D., as his guardian.

Mr A.'s has his permanent residence at the address where his mother and guardian lives. He has a good relationship with his guardian, who visits him once a week; apart from her, Mr A. has no family or friends. He has a disability pension, he smokes and is used to drinking coffee, which they allowed him to do in the psychiatric hospital.

Mr A. is treated with a diagnosis (based on an expert report from 2015) of mixed personality disorder, dissocial, emotionally unstable and narcissistic, and polymorphous addiction to psychoactive substances, which, after several years, led to the development of a psychotic disorder.

Mr A. has a different opinion regarding his diagnosis. He believes that the examining doctors and experts of late have diagnosed him incorrectly – that he does not suffer from any personality disorder and addiction, but rather from a psychotic condition in remission. He believes the negative aspects of his behaviour are caused by the bad influence of the environment where he has been held. In this respect, he draws on the opinions of several court-appointed experts who assessed him in the past. In the 2015 court proceedings, he exercised his right to lodge a complaint concerning the appointed expert.

B.3 Complicated situation in the hospital regarding the performance of protective treatment

In July 2016, 170 patients were held in protective treatment in Psychiatric Hospital A, amounting to a more than 100% increase in the long term, which imposes a significant burden on the provider. (…)

Applications with the court are handled not only by the relevant head doctor, but they are subject to professional discussion in the hospital and require a signature of the director of the hospital, the priority being not to release a socially dangerous patient.

B.4 Regarding the stay of Mr A. in various wards of the hospital

Mr A. stayed predominantly in wards Y and X. Since 11 December 2015, he has been permanently staying in ward X. (…)

Until 23 July 2015, he stayed in ward Y with a one-month stay in ward X. The records kept since 2003 show that Mr A. already stayed 3 times at a department of internal medicine and that, apart from ward Y, he also stayed in ward X in the order of years. More than one person were his examining psychiatrist. Transfers are a matter of agreement between the head doctors in the hospital.

Characteristics of ward Y: Admission department for men, subsequent therapy of acute psychotic phases. The capacity of the ward is 42 beds.

Characteristics of ward X: Department for the treatment of acute restlessness of men and subsequent therapy in case of subsided acute psychotic episodes. Capacity: 43 beds. The department is equipped with CCTV. Out of the men with imposed protective treatment, those who require enhanced surveillance are held in this ward as they interrupt the course of treatment (for instance by escaping or due to repeated states of auto- or hetero-aggression).

B.5 Regarding the course of protective treatment of Mr A. in 2015 and 2016

Mr A. considers the development in the last year to be significant. Based on studying various documents, I have managed to put it in objective terms as follows:

- Based on MUDr. K.'s statement from May 2015 intended for the court, **the medical condition of the patient remained unchanged for many years**; there is no doubt as to his tendency to abuse medication, albeit to a lesser degree as of late. Within the proceedings, the expert stated that the medical condition of the patient was not compensated yet and that there had not been any major positive changes since the last assessment, only his behavioural disorders had been partially reduced. The patient was treated by a combination of psychoactive drugs aimed at reducing tension, restlessness and anxiety. He had been held in ward Y for several years; he was calm, but when his requests were not satisfied, he became negativistic and tense.
- **Every three weeks, he received a leave permit to spend a weekend** at his mother's place in P., from where he would come back in a good condition. During the course of the weekend, he was under the supervision of his mother who was able to provide for the supervision only for the duration of weekend. He received his last leave permit in July 2015.
- In June 2015, there was a change in the position of the head doctor in the ward where Mr A. was staying (MUDr. V. K. was replaced by MUDr. B. B.).
- The expert report as of 10 July stated that the intensity of the defective behaviour had decreased.
- On 23 July, **the patient intoxicated himself in ward Y**. His condition was so serious that he had to be transported to an intensive care unit in P. After returning to the psychiatric hospital and following a weekend stay at the admission bedroom in ward X, he was re-admitted to ward Y. There he was also placed in the admission bedroom. Fluids were rationed to him and their intake was monitored.

- After a twelve-day stay in ward Y, the patient was **transferred back to ward X** on 7 August. The examining doctor at ward Y stated that he was uncontrollable there as his mental condition had deteriorated in the previous days and he refused to co-operate.
- In ward X, he was staying among other patients and had access to the smoking room. **He expressed dissatisfaction with the stay at the ward and requested to be transferred during ward rounds.** In ward X, he had a conflict on 29 August (he was stolen from, but he accused a wrong patient) and on 10 September (he was attacked by the accused patient who actually tried to steal from Mr A. this time). The transfer was in preparation, but on 1 September, Mr A. refused the transfer to ward D, as he wanted to be transferred to ward Y; nevertheless, his stay in this ward was undesirable (because it would have required increased supervision). He later stated that ward D was swarming with criminals, just like ward X. Nevertheless, he would have welcomed to be transferred, but he refused to be transferred to ward D on 16 September. **The head doctor offered to the guardian that Mr A. be transferred to another hospital.**
- On 7 September, a court hearing was held. The court responded to the fact that Mr A. had allegedly violated the treatment regime during the proceedings and requested the hospital to submit an additional report concerning the period from January 2015 to the time of the proceedings.
- On 21 September (ward 13), a restraint was used: **22 hours in the isolation room**.
- There are cases of violation of the treatment regime recorded in ward X: on 23 and 25 September, Mr A was caught trying to manipulate the medication. During the nurses' ward rounds on 30 September, the patient was assessed as constantly trying to cheat the medication; he has a sufficient intake of food and fluids and exhibits a low likelihood of aggression and suicidal behaviour.
- On 5 October, another court hearing was held. Based on an additional report from the hospital, "the court did not find that the assessed person had violated the treatment regime and in what manner", with the exception of the July incident (no intoxication by medication, alcohol or drugs was documented).
- On 6 October, the patient **was transferred to ward Y**. From time to time, he would also be placed in a special bedroom with the aim of enhancing supervision. He was still monitored by the nursing staff due to a persisting risk of intoxication. He was administered crushed medication. After a seventeen-day stay in ward Y, the patient was **transferred back to ward X on 22 October on the ground of being suspected of intoxication**. He exhibited symptoms of intoxication and a laboratory examination showed a nearly four times higher level of benzodiazepines compared to the one measured 12 days earlier. He was even transferred to the department of internal medicine E for one day (records on the possibility of cerebral oedema). The guardian, however, believed that the patient's failure had been caused by frustration from the transfer. At this time, the patient's treatment regime was made stricter and he could no longer stay among other patients (**placed in the**

admission bedroom monitored by CCTV); he was also not allowed to go to the smoking room.

- In November, he filed an application with hospital management for a change of the examining doctor. On 18 November, **a meeting was held between the management of the treatment facility and the guardian**. The mother was still not convinced of the origin of Mr A.'s intoxication and of the necessity of keeping him under strict surveillance. Following this meeting, the guardian requested that his regime be eased, although she was advised on the potential risks.
- **Mr A.'s regime was not eased.** An attempt to steal from another patient of his money on 20 November was assessed by the head doctor as a gross violation of the regime. The patient was "banned to smoke in the smoking room where could get intoxicated with XXX or, for instance, with found medication". A random urine examination on 25 November again showed a high level of intoxication with benzodiazepines (eight times higher that during the previous control), even though the patient was still under a strict regime. The patient admitted the abuse of medication.
- On 26 November, **MUDr. B. B. banned the mother to visit the facility** on the ground of suspicion that two days before that, she had given benzodiazepines to the patient – who was, at that time, already isolated in the admission bedroom from other patients. **A decision was made to create a "benzodiazepine profile"**, i.e. to collect the patient's urine every other day with the existing medication and to monitor the level of benzodiazepines. The mother kept coming to the ward and bringing things to the patient.
- On 26 November, a restraining measure was used: **15 days in the isolation room**. During this period, the level of benzodiazepines was regularly measured (on 27 November, their level decreased to half of the level of 25 November; the level increased again on 30 November); the doctors began decreasing the doses of the regularly administered medication. The laboratory tests first showed a decrease, but then again an increase in the level of benzodiazepines.
- Mr A. resumed his stay in ward X **under the admission-bedroom regime**. The records show that the patient was ill-tempered, uncritical and manipulative, without aggressive episodes, with many demands including smoking; he ate, drank and slept, skipped the ward's community meetings. On 20 December, he unsuccessfully attempted to hide the administered medication. He received crushed medication. There is a record on the mother visiting him only on 17 December; after that, the documents contain a remark of 24 December on an unused collective walk. Several times, the patient received an anti-restlessness injection at his own request, several times he was refused. **The effect of discontinuing the administration of benzodiazepines was confirmed by the negative laboratory results of 10 February**. When assessing Mr. A's condition, the doctors mentioned significantly lower insistence and irritability and higher frustration tolerance.

- On 14 March 2016, he was **released from the admission bedroom to stay with other patients**. This was done at the mother's request (quasi waiver). The examining doctor warned the patient that upon the first attempt to abuse drugs, he would be placed again in the isolation room. The records show that the most important aim of the therapeutic team is to prevent the patient from obtaining a substance or XXXXXXX. The above-mentioned easing was intended as a test of whether the patient was able to sustain further easing of the regime. Mr A. stayed among other patients until 23 March when he tested positive for benzodiazepines again, which was assessed as a serious violation of the ward regime. Due to a risk of intoxication and self-inflicted harm, Mr. A **was transferred to the admission bedroom again**. He was uncritical of his failure and felt harmed by the reaction. He tested positive for benzodiazepines again, this time when he was already isolated in the admission bedroom (6 April). Mr A. was uncritical of both his failures and did not admit them. In the eyes of the therapeutic team, the patient has repeatedly violated his treatment regime. When the staff found tobacco on him, he was advised that he could only smoke in a designated location (26 March).
- On 16 May, a restraint was used: **13 days in the isolation room** for violating the ward regime and fire regulations by smoking in the lavatory. After release, he was placed in the admission bedroom again.
- On 3 June, a restraint was used: **7 days in the isolation room** for violating the ward regime and fire regulations by smoking in the lavatory. During his stay in the isolation room, his urine tested positive for benzodiazepines again (8 June)
- On the day of his release from the isolation room and again afterwards, he smoked in the admission bedroom. No further problems have been registered in the nurses' records. Until the Office employees carried out the inquiry, the patient had been held under the admission-bedroom regime; sometimes, he insisted on being released; he also requested restlessness medication several times.

B.6 Conditions in ward X as of 13 June 2016

Mr A. was held in part of the ward, which is intended for male patients only (capacity of 33 patients). Part T with a capacity of 10 beds is also intended for male patients; according to the staff, it is intended for patients in a slightly better medical condition, for when they are to be transferred elsewhere. Nearly all premises in these two parts are monitored by CCTV that can capture both audio and video. Records are not stored. There is always a designated employee on duty watching video on a screen.

Ward X includes multi-bed room: a walk-through 12-bed room that leads into a 3-bed room; a walk-through 5-bed "admission" room; a 13-bed room. The bedrooms are just rooms with beds. During visiting hours, it is possible to use two extra beds – mattresses on the floor, which is nothing unusual.

With respect to the premises intended for patients, wards T, X and Y are similar to each other – walls painted with bright colours, modern beds in high-capacity (sometimes walk-through) bedrooms, no individualisation, recently restored sanitary facilities, smoking room, bars behind plastic windows, lockable lockers in the hallways for some of the

patients; some of the bedrooms are viewable from the staff room. Ward X is different in that there are neither nightstands nor shelves in the bedrooms; the furniture in the "day-time hall" is robust. Some of the interior doors have metal sheeting. Rooms in ward Y have their own sanitary facilities and CCTV is not in operation there.

Furthermore, during the inspection, ward X was full of large patches of old dirt on the floor, walls, radiators and in the corners; in the bedrooms as well as in the lavatories. The toilets were in a desolate condition: broken booth doors, flushers were too high, some of the bowls lacked seats, there were no towels.

In the morning, the male patients leave the bedrooms and move to the day-time hall, which has direct access to the toilet and smoking room. The smoking room is the only place where smoking is allowed. According to the house rules, the patients may smoke from 6 a.m. to 8 p.m.; outside these hours, smoker's requisites are kept by the medical staff and smoking is prohibited. The patients may return to the bedrooms for the midday nap and then in the evening. The staff mentioned that on these occasions, the patients had to be checked to prevent them from carrying e.g. a lighter into the bedroom. There is no storage space in the bedrooms or shelves for magazines; there were papers under some of the mattresses and plastic bottles on the floor.

There is a different regime in the admission bedroom (sometimes called the "isolation bedroom") if the patients stay here all day for the purpose of being permanently monitored by CCTV. They are isolated from other patients, they cannot go on walks and have no direct access to the lavatories; they must ask the staff to be allowed to go to the toilet and for certain parts of the day, they must use urine bottles. In the admission bedroom, there is no signalling system to notify the staff, but there is an observation window, or the patients can make gestures into the camera or bang on the linking door. The patients accommodated in bedroom No. 2, which is located behind the admission bedroom, are in a similar situation, only they have a direct access to the toilet.

There are several isolation rooms in the ward. Two of them are not upholstered; they are tiled single-bed rooms with a high window and no visual simulation. The other have upholstered walls, a mattress on the floor, squat toilet.

According to the house rules of ward X, the patients can every day take collective walks accompanied by the medical staff; under the day-time regime, one hour in the afternoon is reserved for these walks. The building with ward X and three other wards is neighboured by a garden enclosed with a roughly 2-m-high stone wall. In the garden, there are several benches, a shelter against rain, grass and trees. These premises are not considered safe because the patients may climb over the fence and escape; therefore, some of them are not allowed here.

B.7 The regime to which Mr A. is subjected

The internal guidelines of the psychiatric hospital stipulate, referring to the rather general character of statutory provisions, that each ward or doctor performs the protective treatment and arranges for the regime according to their discretion and capabilities. Walks

around the hospital premises and to town as well as permits to leave are also governed by the regime of the given ward.

Mr A. is held in ward X in order to ensure the highest possible degree of supervision, which, in time, has developed into the strict "admission bedroom" regime or therapeutic isolation (in a safety room pursuant to Section 39 (1)(d) of the Health Care Services Act[4], referred to herein as the "isolation room").

During the on-site inspection in June 2016, Mr A. was held in the admission bedroom together with 2 other patients (all beds were occupied for the night). He spends the whole day there including meal times. He receives no other therapy apart from pharmacotherapy and does not participate in any activities. He is not interested in participating in the community meetings which are held twice a week for half an hour in the ward. He cannot use a locker – all his belongings are kept with the staff, except for some papers that he can keep under the pillow or on the floor. He is a smoker but he is not allowed to smoke (a nurse would have to accompany him to the smoking room where Mr A. is not allowed to enter; he cannot go outside with a nurse either because he would have to go in a larger group, which reduces the degree of supervision). He cannot directly access the toilet and has to ask each time. He cannot go outside He is provided with regular drinks, he can drink coffee and eat the food that his mother brings him. He accepts visits in the visiting room. He is dressed in pyjamas the whole day, always monitored by CCTV. The patient has not been receiving leave permits for a year and has not created the conditions to receive them again in the future. All these aspects of the regime are subject to the discretion of the doctor, not the nursing staff.

Mr A. has been held under this regime for 10 months with breaks of several days (he was already held in the supervision bedroom in ward Y in autumn). He has not been allowed to smoke in the smoking room since 24 November.

The only exceptions were the periods of 15, 13 and 7 days spent in isolation. During these periods, he was held in a small isolation room where he was entirely alone and where he also ate (during at least one of these periods he stayed in a room with a mattress, i.e. "on the floor"). Again, he was deprived of all human contact, staying outside and smoking.

Details on the visits: (…)

Details on the smoking: In September and October, when Mr A. stayed in ward X under a regime among other patients, he could smoke and even had an electronic cigarette (the charger was kept by the staff). Since 22 October, when he was placed in the admission bedroom, the patient's access to smoking has been impeded. Smoking is prohibited in the (admission) room and sanitary facilities. Mr A. is not allowed any outings, he is usually not invited to collective supervised walks, he is not being taken to the smoking room. According to the nurses, smoking can only be allowed by a doctor. According to the head doctor, Mr A. cannot possess cigarettes because he would trade them. Therefore, there is no way for him to smoke.

4 Act No. 372/2011 Coll., on health care services and the conditions for their provision, as amended.

However, Mr A. has repeatedly requested to be allowed to smoke, as documented by a number of records made by the staff and complaints made by the patient.[5] No record indicates that his requests were met. On 14 November, he was caught trying to trade food for cigarettes in a diaper smuggled by another patient into the admission bedroom. Even the records from when the patient was held in the isolation room show that he made request on a daily basis to be allowed to smoke. The patient is apparently not allowed to smoke even after the release from isolation and keeps requesting it. He only received an electronic cigarette after easing of the regime on 14 March 2016. When he was restricted in the admission bedroom again, he repeatedly violated the regime by smoking.

The staff reacted by advising him on fire regulations, making records on repeated violations of the regime, and placing him twice in the isolation room for several weeks. The mother said that during discussions in May and June, she asked for an electronic cigarette for her son, but was rejected.

Details on phone calls: When the patient is under the admission-bedroom regime, he cannot use his cell phone. Mr A. is allowed to call his mother from hospital phone; more frequently, he accepts phone calls from her. The patient accepts the mother's phone calls in the nurses' office, i.e. in the presence of the staff. Both the mother and the patient criticise the lack of privacy. Remarks on the nature of the phone calls appear in the nurses' records, too.

Details on going outside: In early September 2015, when Mr A. stayed in ward X with other patients, he was allowed to go on collective walks (see the nurses' records). Even at the time when he stayed in the admission bedroom, the nurses' records occasionally contain a note on him not going for the collective walk. But more often than not, there is nothing in the records on him going outside; frequently, they just contain a general "no requests" remark. Gradually, Mr A. acquires the status of a high-risk patient and the staff is banned from accompanying him to the smoking room. To conclude, I consider it proven that under the regimes of admission bedroom and isolation room, Mr A. was entirely deprived of the possibility to go outside.

(…)

B.8 Violation of the treatment regime and the patient's dangerous behaviour

The therapeutic team justifies the tightening of the regime by the patient's constant failures when he stays among other patients. His actions are frequently assessed as violations of the treatment regime and sometimes as dangerous.

5 The nurses' record of 4 November is telling in this sense: "During a phone call with his mother, he threatened to break the windows if we do not let him smoke. He asked for an electronic cigarette so he could smoke in the admission bedroom."

B.8.1 Regarding the nature of Mr A.'s dangerous behaviour

In case of Mr A., this behaviour mainly includes intoxication as a means of inflicting self-harm. Lately, he has also been reported to endanger other patients by manipulating with fire during secret smoking. When Mr A. gets aggressive, it is only verbally.

According to the statement provided by the head doctor MUDr. V. K. to the court in May 2015, there was no doubt that the patient had tendency to abuse medication ("although to a lesser degree lately"). In the past, the abuse also occurred due the mother's failures.[6] During review proceedings in 2015, an expert stated that the patients was entirely uncritical of his abuse of alcohol and psychoactive drugs. In his report, he noted that due to the excessive consumption of these substances,[7] the assessed person had psychotic episodes (so-called toxic psychosis) and showed a tendency to behave aggressively.

The case involves both intoxication by XXXX and by medication or other chemicals. The patient's intoxication in July 2015 took place against the backdrop of repeated instances of such behaviour in the past. XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX As regards chemicals, Mr. A. tried to obtain medication, hygiene products and detergents in the hospital. The staff consider his behaviour within the broad context of his hospitalisation of twenty years. Mr. A. is still seen as a person who used to try to break into the staff office.

The psychiatrists note that intoxication could lead to the patient's death. Within an interview, the head doctor explained that the patient experienced altered consciousness, both in qualitative and quantitative terms; he would become paranoid and no one could say with any degree of certainty what would happen next.

B.8.2 Violations of the treatment regime and signs of risk

Given the degree of surveillance over Mr. A., the staff made records on his condition several times a day. These indicate **violations of the ward's internal rules and of the treatment regime**:

- On 23 and 25 September, he was caught trying to tamper with the issued medication. During the nurses' ward rounds on 30 September, the patient was assessed as constantly trying to cheat the medication.

6 A quote from the ruling of the appellate court: "Although it cannot be concluded that these visits had such significant re-socialising effect as to substantiate transfer to another form of treatment, as there had also been failures on the part of the mother in the past, for instance when she had not been able to prevent the assessed person from acquiring alcohol and other psychoactive substances, this motivation continues to have a positive effect on the protective treatment, which, however, retains its detention purpose."

7 It was considered proven in the court proceedings that the patient had drunk some aftershave water in January 2014, he had been found to possess alcohol in February 2014 and he then had tried to steal Tramal, a medicament, and he had attempted to break into the head doctor's office; in March, he had drunk some aftershave water, in May (still in 2014), he had drunk some aftershave water and later another three bottles of aftershave water.

- He was repeatedly caught hiding medication in his pockets (epicrisis of 27 November).
- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.
- Instances of intoxication accompanied with significantly increased levels of benzodiazepines have been proven – in October in ward Y and in November in ward X (when he was already subjected to the strict regime), in March when he briefly stayed with other patients and in April when he was in the strict regime.

These are specific records; general records are more numerous – nonetheless, I do not consider them entirely conclusive. The records also indicate other lapses apart from intoxication: an attempt to steal from another patient on 20 November and several instances of violation of the ban on smoking and racketeering.

Some of the records include not only a description but also an evaluation. These are notes concerning gross violations of the regime (attempted theft in November), serious violations of the regime (in March) and repeated violations of the treatment regime (11 April).

Within an interview, Mr. A. admits that he used to obtain medication for himself. As regards the incident from March, he states the same as he did at that time, i.e. that he drunk someone else's intoxicated coffee. He knows that he was put in an isolation room the last two times for violating the ban on smoking.

Head doctor B. admits that, despite all surveillance (including surveillance over intake of medication), the patients in ward X are able to collect medication and later abuse or trade it. It is also impossible to control the visitors completely.

The relationship between the hospital and the custodian is affected by an unproven suspicion that the custodian obtained medication for the patient with which he intoxicated himself in November 2014. The custodian denies this. She also states that there has been traffic in medication in the hospital for years. She admits her son's involvement in it. She further admits that she obtained the medication for him several times in 2003 until the then serving head doctor prohibited her from doing so and she never violated the prohibition.

B.8.3 Considerations on preventive detention

The patient's medical records include considerations of the psychiatrists on the possibility of transferring him from protective treatment to protective detention: notes of the psychiatrist on the intention to apply with the court for a transfer from protective treatment to protective detention following the intoxication with benzodiazepines in November 2015; record by the head doctor of 3 June 2016 stating that he would submit the application already. MUDr. C. states that the patient's behaviour may lead to a transfer from treatment to protective detention because the treatment is ineffective (his record of 1 June).

B.9 Care currently provided and planned for the future

Mr. A's examining psychiatrist is MUDr. G., while MUDr. B., the head doctor, also frequently communicates with the patient and his mother. They both agree on the line of therapy and so does another treating psychiatrist. The patient receives a psychiatrist's attention on a daily basis, the nursing staff also pay intensive attention to him and records in the documentation are made several times a day.

Mr. A.'s intake of fluids has been regulated in the long term. At times, he was prescribed crushed medication. In the entire time recorded in the medical records that I examined, he had not taken part in any activities or therapeutic programmes. The patient does not take the advantage of the community meeting that takes place twice a week for half an hour.

In June 2016, Mr. A. only received mild medication. When he returned intoxicated from ward Y to ward X in October 2015, the psychiatrists decided to gradually stop administering him some of his medication, so as to be able to verify their suspicion that he was abusing benzodiazepines. It is now possible to see clearly from the tests if the patient abuses any medication.

Since autumn 2015 the therapeutic actions concentrated on the endeavour to keep Mr A. "clean" by isolating him, with several failed attempts at relaxing the regime. Any lapse is considered as a threat for his life.

- November 2015, agreement to try to release the patient from the admission bedroom: "If the patient remains calm and exhibits no objectionable behaviour, the mother and the patient will draw up a request for relaxing the regime and placement of the patient with the other patients in the ward, indicating that they have been expressly informed and are aware that the patient may die of intoxication XXXX."
- In February 2016, the patient was released from the admission bedroom to stay with the other patients in ward X based on a written waiver issued by the custodian.
- "We planned to observe the patient (note: in the admission bedroom). But he was caught smoking in the lavatory on 16 May. Given the dangerous nature of this behaviour (possibility of a fire in a room not intended for smoking), the patient was placed in therapeutic isolation, from which he was released on 29 May. He was completely uncritical of his behaviour. We planned to keep him in the bedroom until the end of August and allow him to stay in the hall with the others if there are no incidents" (epicrisis of 3 June).
- On 3 June (following another instance of smoking), the head doctor notes "complete therapeutic hopelessness".

I did not find any other content that could be considered **a plan of further therapy** in the records. In the on-site inquiry, the head doctor also summarises the plan of therapy by stating that if the patient remains clean until August 2016, he will allow him to stay in the "day-time hall" and if he remains stable, then he can transfer to ward N. A nurse summarises the care provided to the patient by stating: we protect him from intoxication

XXXXXXXXXXXXXXXXXXXXXXXXXXXXX. He is not aware of any direction of the patient's stay.

In June, the patient himself was unaware of the plan for August – however, this was a result of an agreement with the custodian (on 25 May, a meeting was held with MUDr. C. concerning her request for a transfer from ward X), which was aimed at the possibility of a transfer to ward N. This was allegedly mentioned by MUDr. C. on 25 May and again in another meeting held on 1 June; the fitting-out work was supposed to last another two to three months. According to the custodian, MUDr. B. responded to this by making the transfer conditional on the patient not violating the treatment regime for 3 months; smoking would also be considered a violation and an electronic cigarette was not allowed. The custodian believes that this condition was unrealistic, which is sadly confirmed by the patient's lapse of 3 June, when he was isolated for having smoked.

B.10 Restraints

B.10.1 Restraint on 21 September 2015 (22 hours in the isolation room)

In the morning of that day, the head doctor made a round of the ward and the patient unsuccessfully asked to be transferred back to ward Y on that occasion. According to a nurse's record, the patient was banging and kicking the door of the staff room the whole morning; at 2:35 p.m., Tisercin 2 amp. i. m. (prescribed in advance as optional medication "in case of restlessness") was administered to no effect. "The patient keeps banging the door, verbally aggressive, impossible to calm down ... put me in isolation!!!" Accommodated, at 3 p.m. placed in therapeutic isolation, examining psychiatrist informed." A psychiatrist's record was made at 3:17 p.m.

The staff obviously tried to address the situation by taking gradual steps. The sedatives were administered by the nurses without calling in the psychiatrist and the nurses also used the isolation room on their own and the doctor only made the record later.

The restraint lasted for 22 hours in total. The doctors comment on the justification of keeping the restraint in place in their records as follows: (...)

The nurses regularly checked on the patient. Their records do not indicate any aggression. He slept in the night, he allowed his blood to be collected twice in the morning, he had his breakfast. When his mother arrived at 1 p.m., he met her in the visiting room. At 1:30 p.m., he was allowed to join the other patients.

The documentation shows no fact-based assessment of the necessity of keeping the restraint in place from the morning of 22 September. The order of the court which reviewed the continuation of protective treatment states that the examining psychiatrist noted with respect to the restrain that "isolation had been used because the patient had been harassing the people around him by kicking the pharmacy door because he had not wanted to be hospitalised in the ward".

Reports on banging the door were included in earlier nurses' records – this appears to be the patient's way of demanding various things ("he demands that his electronic cigarette be recharged outside the recharging hours", 4 September 2015).

B.10.2 Restraint in place from 26 November 2015 (15 days in the isolation room)

The patient was in the admission bedroom, showing signs of intoxication by benzodiazepines, which was already being addressed since the previous day. A round of the ward took place (record made on 7:19 a.m.). A member of the cleaning staff reported that the patient tried to steel disinfectants from his cart at 7:30 a.m. He was placed in therapeutic isolation – I infer that this was done by the nurses because a doctor's report was only made at 9:05 a.m. while the restraint was used earlier, as follows from a nurse's record of 8:08 a.m. MUDr. G. made the following decision: "The patient has been repeatedly intoxicating himself with medication, XXXXX now tried to steel detergents from a cleaning cart. His behaviour is completely unpredictable, the patient poses a threat for his own life, is not aware of this. He was ordered to stay in therapeutic isolation."

The psychiatrists comment on the justification of keeping the restraint in place in their records as follows:

- 4 hours of the restraint: "Uptight, he downplays everything, he claims not to have taken any benzodiazepines, makes up a story that a doctor let him take a walk yesterday... seriously damaged by ongoing abuse of drugs."
- 8.5 hours of the restraint: "Completely unaware of reality, disoriented, unable to provide any valid answers, asks about unreal things, isolation absolutely necessary, otherwise, his toxi. tendencies will lead to a threat to his life; at times, he bangs the door and asks for food."
- 12 hours of the restraint (at 8 p.m.): "The patient shows significant post-pharmacological inhibition, unclear pronunciation, almost incomprehensible, deteriorated motor skills and co-ordination of movements. He is completely uncritical of his intoxication, downplays the situation, tries to blame others. Severe personality disorder. Demands to be allowed to smoke and call his mother. It is necessary to keep him in therapeutic isolation where it is possible to monitor him to make sure he does not consume anything else and the intoxication can subside; any further consumption of medication could threaten his life."
- 13 hours of the restraint: "After my entering to the isolation room, he suddenly gets on his feet, agile, reduced psychomotor speed, expression simple, spontaneously states that he would like to go out; he does not say anything about the circumstances of the restraint, completely uncritical. The risk of self-harming behaviour still persists; the patient tends to intoxicate himself with various substances as available in the circumstances. Unpredictable."
- 23 hours of the restraint (at 7 a.m.): "Dysphoric, comments practically on nothing, does not respond to questions and stimuli, dismissive."
- From an epicrisis drawn up at 10:33 a.m.: "Currently toxi. of the urine to ascertain 'normal' levels of BZD with the prescribed medication. For this reason, the patient

is in therapeutic isolation; if released, he would be dangerous for himself due to the possibility of intoxication by virtually anything."

- 30 hours of the restraint: "The patient now pronounces words normally, says that he does not understand the reasons for his stay in isolation, he does not understand at all why he is in therapy ... (...) Do not release from therapeutic isolation over the weekend. The plan is for the patent to be strictly isolated for 14 days with regular toxi. analyses of the urine every other day."

I believe that, in the beginning, the restraint was not imposed based on the patient's aggression. While the nurses' records indicate that the risk of aggression remains, this is documented merely by kicking the door. Since there is no signalisation in the isolation rooms and the patient saw the use of the restraint as injustice, his behaviour can be considered an understandable response. I infer that the restraint was motivated by the effort to monitor the patient so as to make sure that he does not attempt to obtain something.

I consider the context of the incident as important – the attempt to steel from another patient a few days earlier, then signs of intoxication, then its manifestations, including the attempt to steel from the member of the cleaning staff. The development of the situation could not have been predicted. The team adopted a strategy of regular analyses and kept the patient in isolation.

The patient's condition improved after a day spent in the isolation room. On Friday, the psychiatrist prohibited releasing the patient from isolation for another two days. The psychiatrists would stop administering some of the medication in the following days and this is easier with the patient staying in the isolation room.

Thus, the restraint continued. His requests that he be allowed to smoke were not accommodated. Nurses made regular records of check-ups. The patient was usually morose, demanded to be allowed to smoke, had nonsensical requests, tended to lie down; the nursed sometimes recorded that "the risk of aggression remains" and they noted that "the risk of unpredictability remains" at other times. The patient had his meals in the isolation room, there is no record of any outing, smoking, activities; the patient stayed in the room all the time. A record from 1 December states that the patient is completely out of the real world, he believes that he has been in insolation for 4 months. On 2 and 4 December, he was kicking the door, on 5 December, he "seems almost unaware of reality", on 8 December, he thought that it was already after Christmas and he had gone home on a leave.

Example of a psychiatrist's record on regular evaluation of justification of keeping the restraint in place: "Completely uncritical, uptight, insistent, impossible to calm down (...), keeps going on about the transfer. Significantly manipulative. Persistent risk of auto-aggressive behaviour. Therapeutic isolation necessary." (MUDr. B. on 30 November at 7:03 a.m.)

A significantly high level of benzodiazepines in the urine was found also on 30 November. This was while the patient was already for the 4th day in the isolation room and the previous analyses had shown ongoing decreases. The psychiatrists decided to gradually

stop administering benzodiazepines within the regular medication so as to be able to make objective conclusions on the patient's condition. The patient's stay in the isolation made the process easier. "We monitor the BZD profile in regular collections. Yesterday, after consuming food that his mother had brought him, there was again a slightly higher level than usual with our medication. For an objective evaluation, it is necessary to monitor him for a longer period of time and with a regulated intake of fluids. For this reason, the patient remains in therapeutic isolation."[8]

The patient was released from isolation on 8 December and the record does not indicate any connection to his condition. While the psychiatrist's record of 11:31 a.m. states that the patient is currently calmer and promises to co-operate and exhibits no aggression, this is in no way different from the condition in the morning when another psychiatrist confirmed at 7 a.m. that the restraint should be kept in place. **Shortly after that, a psychiatrist decided that the patient should be isolated again** in order to assure permanent surveillance; no signs of aggression. Since he was transferred to women's ward K, I assume that he might have been released that morning because the isolation room in ward X was needed for another patient. Mr. A. was allowed to see his mother in ward K. On 11 December, he was transferred to ward X and the restraint continued; the nurses' record indicates that he showed no signs of restlessness.

The restraint ended on 12 December at 4:10 a.m. and the patient was placed in the admission bedroom: "The patient slept through the night, woken up due to the necessity to vacate the therapeutic isolation for reasons of emergency admission of another patient." (MUDr. D.). Therefore, the patient stayed in isolation for 15 days and nine psychiatrists made records on "justification of keeping the restraint in place". Their records seem purely formal because they actually adopted the above-recorded decision on total isolation of the patient.

The patient found the restraint hard to bear, asked to be released, his remarks made no sense.

B.10.3 Restraint in place from 16 May 2016 (13 days in the isolation room)

On 16 May, when he was in the admission bedroom and he was not allowed to smoke legally, the patient violated the regime of the ward by lighting up a cigarette in the lavatory in front of an orderly and he refused to quit at once and leave the lavatory. The nurse made the following record in the documentation: "It was necessary to lock up the therapeutic isolation at 3:50 p.m. with the assistance of 3 orderlies; the purpose was to prevent him from violating the ward's regime and fire regulations and to eliminate a fire in the ward. MUDr. J. informed of everything." The doctor noted: "... he insisted on having his way, there is a risk of fire, isolation necessary, he keeps talking on."

As regards the justification for using the restraint:

- less than an hour of the restraint: "Only complains about his stay here and violations of the patient's rights, completely downplays his severe addiction to

8 A doctor's record of 4 December 2015

drugs... it's not that, he curses the head doctor and the director, paranoid, dysphoric" (MUDr. J.).

- one hour of the restraint: "Patient uptight, complains, paranoid, completely uncritical, downplaying the situation, had dinner, fluids administered" (nurse Š.).
- 3.5 hours of the restraint: "... increased irritability, impossible to calm down verbally, uncritical, increased intrapsychic tension, no psychotic production, persistent risk of auto or hetero-aggression" (MUDr. Č.). An hour later, the patient was already asleep.
- 15 hours of the restraint (6:44 a.m.): "He keeps going on, puts his head under his blanket, he did not do anything, he has a right to smoke... everyone keeps destroying and limiting him" (...)" (MUDr. J.).
- 21 hours of the restraint (1:04 p.m.): "Sarcastic, unable to control his behaviour, paranoid, ready to complain, remains in isolation" (MUDr. J.).

The nurses further noted that the patient had never been aggressive, had his meals and medication. It was noted that "unpredictable behaviour persists" and "risk of unpredictable behaviour still persists" (records from 17 May), but the reasons for this are unclear just like the threat the nurses expected when they took away his fire. In the nurses' round of the ward of 24 May it was summarised that the "patient had been placed in therapeutic isolation due to repeated and intentional violations of the ward's regime and especially due to a violation of the fire regulations." Head doctor B. considers the patient's behaviour as a serious violation of the regime (record of 17 May).

In total, he spent 13 days in isolation and he also had his meals there. The prolongations of the stay in the isolation room were signed off by 14 psychiatrists.

- In the records, the psychiatrists from ward X comment on the patient's ability to respect the rules of cohabitation and note that he is not able to admit his failure and fault and states that he has the right to smoke. For example, head doctor B stated: "For now, his conduct and behaviour does not provide a guarantee of problem-free behaviour and conduct in the bedroom; therefore, it is necessary to keep him in therapeutic isolation" (17 May). "No developments in the situation. Shows obvious lack of will to communicate, unfriendly mood, it is obvious that it takes a lot of effort for him to control himself and communicate at least within the limits of basic decency. He is always the second to say hello – if he says it at all" (27 May).
- Some of the records indicate efforts to induce remorse in the patient and make him admit his fault, i.e. an educative goal: "Production obviously shows preference of only himself and his interests. Pities himself and acts hurt. Absolute lack of consciousness or any humility" (MUDr. B. on 27 May).
- Other doctors state in their records that the patient is negativistic and unpredictable and that there is a risk of hetero-aggression (not specified in any more detail).

The patient was released from the isolation room on Sunday 29 May at 12:50 p.m. when he promised the doctor on duty that he would not smoke cigarettes either in his room or in the lavatory.

B.10.4 Restraint in place from 3 June 2016 (7 days)

On 3 June, at a time when he was in the regime of an admission bedroom and was not allowed to smoke legally, the patient violated the ward's regime by using fire in the lavatory and admitted that he intended to smoke. MUDr. B. decided (at 9:50 a.m.) on his placement in the isolation room: "Probably intended to smoke; at first, he denies an absolutely objective fact ascertained when he was caught (lies), he later admits with inappropriate complaints and remarks bordering on threats. By his behaviour, the patient keeps demonstrating that he is not able to control himself at all and that he does not want to observe the ward's regime. Repeatedly causes situations posing a threat not only to himself but also other patients (e.g. fire in the bedroom). He completely ignores any well-intentioned advice. We constantly discuss his behaviour with him and also his mother – custodian and we inform her of the lapses." A frustration from therapeutic and educative failure seems to be manifested here.

When assessing the justification of keeping the restraint in place, the psychiatrists comment on the patient's attitude to his failure and whether or not he admits his faults and provides a guarantee of problem-free behaviour. Example of a report, 24 hours of the restraint (9:33 a.m.): "He sleeps in the therapeutic isolation, easy to wake up, not interested in any discussion, flatly states 'I am locked up', has no requests, does not state any problems, somat. nihil ac.; due to unpredictable behaviour posing a serious threat to people around him, the restraint must be kept in place." The patient expressed his conviction that he had been placed in isolation unfairly and, from time to time, he insisted that he should be released.

The restraint was relieved in the morning of 10 June due to a lack of capacity: "The patient is morose and downplays the situation, but there is a more dangerous patient in the ward." (MUDr. O.) He had a cigarette in the admission bedroom already on 10 June in the evening. From a nurse's record: "Due to a lack of capacity of therapeutic isolation, he is kept in the admission bedroom, subject to surveillance."

B.11 Complaints and attempts to change the patient's circumstances

B.11.1 Complaints in the psychiatric hospital

(…)

B.11.2 Criminal complaint

Mr. A. drew up a criminal complaint on 3 March 2016 concerning unlawful acts by head doctor B. I am not familiar with the contents; I have merely been indirectly acquainted with some of its parts. He sent the complaint to a number of institutions (the Ministry of the Interior, General Inspectorate of Security Forces, the Police Presidium). Within the

Police of the Czech Republic, the complaint was investigated into by the 1st General Crime Unit of the P Local Department, to which the complaint was forwarded on 6 April.

The Police performed an investigation pursuant to Section 158 (1) of the Code of Criminal Procedure[9] "and following qualified assessment of all the facts found, it was stated that the case does not correspond to the merits of any crime and, therefore, no reasons were found to take any steps within criminal proceedings pursuant to Section 158 (3) of the Code of Criminal Procedure. No infraction or other administrative offence was found." **The case was closed on 17 May 2016 without any further measures being taken.** Mr. A. and his custodian were informed accordingly and were advised that if they did not agree, they could contact the State attorney.[10]

As regards the investigation in the hospital, I have been informed that the Police body contacted directly MUDr. B., against whom the complaint had been made, on 12 April 2016. The Police asked in writing for information concerning Mr. A.'s status; the doctor learned from the request that Mr. A. had lodged a criminal complaint concerning his unlawful conduct. MUDr. B. provided a specific response. There are no indications of the Police performing any investigation directly at the psychiatric hospital.

B.11.3 Complaint lodged with the Public Defender of Rights

I received the complaint on 12 April 2016.

B.11.4 Complaints lodged with the court

The hospital's documentation includes (a copy of) the patient's letter to the District Court in P. of 12 April 2016, whereby he asks for help because he is being subjected to "cruelty" and expresses a lack of confidence in the hospital's management. He asks for an intervention, specifically for initiation of proceeding on the permissibility of him being kept in the institution any further. The court initiated the proceedings and subsequently discontinued them at the patient's request.

B.12 Summary of the positions of the parties involved

(…)

C. The Defender's assessment of the case

C.1 Previous recommendations of the Defender

My predecessor made an inquiry into the conditions of performance of protective treatment in Psychiatric Hospital A in 2013 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX. JUDr. Varvařovský (previous defender) found several errors on the hospital's part and the inquiry led to issuance of a Defender's opinion with proposed remedial measures:

9 Act No 141/1961 Coll., the Code of Criminal Procedure, as amended

10 I quote from the notice of 7 July 2016, which I requested from the Police.

- the document addressed, in particular, the humanly degrading accommodation in 14- and 11-bedded rooms (in ward H)
- and examined whether patients in protective treatment could go outside every day unless this was prevented by their medical condition (in which case an entry should be made in the patient's records).

My predecessors also dealt with the use of restraints in hospital during several systematic visits. Most recently, in 2012, JUDr. Varvařovský found an error on the part of the hospital where a patient had died in a XXXXXXXXXXXXXXX net bed. In this respect, it should be noted:

- The Defender has criticised the use of restraints in situations where they were not absolutely necessary (in the absence of appropriate conditions for care of restless patients, restraints are used even if this is not necessary to avert risks for the life, health or safety of a patient or other individuals, i.e. they are used as means of prevention).
- Furthermore, the Defender laid down the following recommendation concerning the use of restraints: accept the decision of paramedical staff to use restraints only in exceptional cases requiring an urgent solution.
- In respect of control activities, the Defender recommended the following: constantly monitor the formal standard of medical records.

C.2 Treatment and care of a patient

C.2.1 Legislation

Inviolability of the person and of privacy is guaranteed. It may be limited only in cases specified by law. Nobody may be subjected to torture or to inhuman or degrading treatment or punishment.[11] The prohibition of torture and ill-treatment is an "absolute" prohibition which is not justifiable under any circumstances, regardless of the victim's behaviour.

"The position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. (…) A measure which is a therapeutic necessity cannot be regarded as inhuman or degrading."[12]

A patient is obliged to undergo the individual treatment procedure determined for his/her protective treatment; the patient has the right to choose among the available treatment alternatives.[13] Individual treatment procedure includes the treatment regime – a set of

11 Article 7 of the Charter of Fundamental Rights and Freedoms. Cf. also Article 3 of the Convention for the Protection of Human Rights and Fundamental Freedoms (hereinafter also the Convention).

12 Judgement of the European Court of Human Rights in Bureš v. the Czech Republic of 18 October 2012 No. 37679/08, para 87; accessible at http://hudoc.echr.coe.int/eng#{"itemid":["001-160192"]}

13 Section 88 (1)(a) of Act No. 373/2011 Coll., on specific health care services, as amended

measures supporting the treatment and minimising its potential risks.[14] A patient is also obliged to observe the internal rules; the internal rules may not interfere with the patient's rights beyond what is absolutely necessary especially for a proper operation of the medical facility and respect for other patients' rights.[15]

Protective treatment may only involve the restrictions on human rights stipulated by law and there may only occur to the extent necessary for attaining the purpose of the protective treatment if the purpose cannot be attained otherwise.[16]

C.2.2 Purpose of protective treatment

According to an expert's opinion, the patient's protective treatment mainly follows detention purposes. The Regional Court has confirmed that the detention purpose of protective treatment continues to exist in Mr A.

C.2.3 Transfers to ward X

Increased attention has been paid to the patient's intake of fluids since 23 July 2015. With a view to ensuring supervision, the patient was transferred from ward Y to ward X in August 2015. Similarly, the patient's transfer on 22 October was aimed at ensuring a higher degree of supervision after his benzodiazepine levels suddenly "shot up" (even though he had been placed in an enhanced supervision bedroom in ward Y, together with several other patients). Ward X responded to this situation by enhancing supervision, especially in terms of medication.

In my opinion, there can be no objections on the procedure taken by the hospital. It is up to the provider to decide how to ensure a proper standard of professional care, although it is possible to review whether individual measures constitute unreasonable limitation of the patient's rights. I consider that in this particular case, the transfers in themselves did not limit the patient's rights.

C.2.4 Conditions in the ward

Many parts of ward X are in a dismal condition. It is obvious that the equipment suffers considerably from the patients' restless and aggressive behaviour. This explains why the ward is in part desolated, but does not justify the dirt. Patients are placed in large-capacity bedrooms only. Ward X may be acceptable for a temporary short-term stay. **However, the conditions there do not provide a standard of therapeutic environment that would be suitable for a long-term stay.**

Even the security situation is not good – 13 men sleep in a bedroom behind a walk-through room, without any signalling device. The staff considers it necessary to do a body search looking for lighters and cigarettes before the patients are permitted to enter the bedroom. An individual patient can put the whole large group at risk.

14 Section 3 (3) of the Health Care Services Act

15 Section 41 (1)(b) or Section 46 (1)(a) of the Health Care Services Act

16 Section 83 (3) of the Specific Health Care Services Act

I am afraid this is not a unique problem – the conditions in ward Y are similar, and the same was true in ward H during my predecessor's inquiry in 2013.

C.2.5 Ban on the mother's visits

As an exception, the provider may ban a person from visiting a patient in the event of justified suspicion that the visit would seriously disrupt the individual treatment procedure.[17]

The ban on visits by the patient's mother issued in November 2015 can be seen as an exceptional measure; however it was not imposed for a single visit but sweepingly for the "mother's visits" as such. It lasted several weeks. The head doctor explained this by suspected introducing of prohibited substances for the patient who was intoxicated at the time. Thus, the head doctor did not act arbitrarily. Nevertheless, the prohibition continued and hence became unlawful. I believe that if not earlier, then as soon as the patient's benzodiazepine levels soared again a few days later in the isolation room, it was time to review whether the prohibition of visits for the patient's mother was still justified.

C.2.6 Non-permitting short-term leaves from the medical facility

The law makes the permission to leave, and issuing a leave permit, conditional on the state of the patient's health and on ensuring that the purpose of the protective treatment is not compromised and the individual treatment procedure is not disrupted.[18]

A short-term leave from the medical facility does not fit in the existing care plan. In spite of my reservations on the direction of the care, I agree that a leave permit would be problematic in the present situation, and looking in the past I do not see a moment when a leave permit should have been issued and was not. Thus, in this respect, I do not see any error on the hospital's part.

C.2.7 Use of restraints

(1) Legislation

Once the personal freedom of an individual is restricted, each use of physical force that is not **necessitated** by the person's previous conduct represents interference with human dignity. The use of restraints must be necessary in light of the circumstances and must be aimed at preventing existing or threatening harm and must be proportionate to its aim. For a restrictive measure to be a matter of last resort, its use must be preceded by attempts at milder alternatives unless this would clearly not lead to averting the danger

17 Section 85 (1) (a) of the Specific Health Care Services Act

18 Section 86 of the Specific Health Care Services Act: (1) A provider providing protective treatment (aside from imprisonment) in the form of in-patient care may permit a patient, on the patient's request, to leave the medical facility for a short time after assessing his/her medical condition; the provider issues a leave permit for this purpose. (2) A leave permit may be issued if the patient's medical condition is stabilised and it is reasonable to assume that the medical condition will not change during the short leave in such a way as to result in the defective behaviour due to which the protective treatment was ordered. Permitting a short-term leave from a medical facility may not be at variance with the purpose of the protective treatment and may not disrupt the individual treatment procedure.

(**the subsidiarity principle**). The most moderate restraint must be chosen from among the alternatives available. [19]

These are the basic principles following from the Charter of Fundamental Rights and Freedoms and the Convention for the Protection of Human Rights and Fundamental Freedoms and reflected also in the Health Care Services Act. The law expressly stipulates that restraints may only be used if they are aimed at avoiding a direct threat to life, health or safety of a patient or other persons, and only during the time when that aim exists. As a rule, a decision on the use of restraints is to be taken by a doctor.[20]

Basic principles are also applied by the CPT Standards[21], which, in my opinion, are fully applicable to Czech psychiatric hospitals. The Standards place emphasis *inter alia* on maintaining the staff-patient relationship, in spite of the necessity to restrict free movement. This is to be achieved by a debriefing concerning the restraint situation and also, as far as possible, permanent presence of the staff during the restraint.

(2) Assessment of Mr. A.'s case

I examined the above-described four cases of using means of restraint – isolation room. **I believe that the restraint was largely unnecessary and hence unlawful:**

- It is apparent from the restraint records of 21 September 2015 that at least from the next morning (after the patient was restrained overnight and co-operated with nurses in the morning), the doctors had no justification for approving its continuation. Concerns about possible danger were no longer justified because there was no specifiable serious danger that could only be averted by restraining the patient. In addition, it seems that the staff put an end to the restraint not based on their own judgement but rather because a visitor arrived.
- On 26 November Mr. A. was placed in the isolation room after showing signs of intoxication. I agree that a patient's life and health are at risk if he shows signs of intoxication and behaves unpredictably, actively attempting to get hold of another chemical substance. However, the patient's condition improved after a day spent in the isolation room. It is obvious from the above-cited records that the stay after that point in time was intended to facilitate obtaining the patient's "benzodiazepine profile". While the psychiatrists had a plan, it served as a long-term treatment strategy, rather than to prevent an immediate danger. From a certain time the placement in the isolation room was not a response to an imminent danger and as such was not necessary; it was rather a method of

19 Cf. Bureš v. the Czech Republic, para 86, 96, 97. The court repeated this e.g. in the decision in M. S. v. Croatia (No. 2) of 19 February 2015 No. 75450/12 (cf. para 97 and 98); abstract in Czech accessible at http://datalot.justice.cz/justice/judikatura_eslp.nsf/0/584910A4C9F7417EC1257EC40036FD89/$file/M.%20S.%20proti%20Chorvatsku%20(č.%202)_anotace.pdf?open&.

20 Section 39 (2) of the Health Care Services Act

21 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. CPT Standards, "relevant" parts of CPT reports [online]. Strasbourg: Council of Europe, 2002, partly revised 2016 [accessed 1 September 2016]. Accessible at: http://www.cpt.coe.int/czech.htm. The section Means of Restraint in Psychiatric Establishments for Adults was recently added in the Czech translation [published in the 16th General Report, CPT/Inf (2006) 35].

ensuring supervision. (After all, later, in the same situation, the patient was kept "only" in the admission bedroom.) I estimate that this situation lasted for more than 10 days. If the staff took compensatory steps for isolating the patient from other patients and restricting him in his free movement, the situation could be evaluated differently. However, the restrictive impact of the isolation room fell on the patient with a full strength, without any relaxation whatsoever: he was left without any human contact other than staff interventions and was not allowed to smoke and go outside. He demanded to be released without success; the restriction was not lifted until the isolation room was needed for another patient. I am extremely concerned about the fact that several psychiatrists actively used means of restraint as a regime measure, as well as that many other doctors accepted this decision. **A total of 9 doctors were individually responsible for this situation.**

- On 16 May the patient was placed in the isolation room due to smoking in the lavatory. I see a particular threat in that he violated the rules in the presence of an orderly and refused to comply, thus ignoring the authority of the staff. Nevertheless, after he was "subdued" by the combined forces of several orderlies, I do not see why anyone's life should be threatened any longer. As documented above, this was not the first time the patient smoked where smoking was not permitted. The staff could have assumed that the patient could repeat that hazardous conduct. However, they did not do anything to minimise the risk other than advising the patient of the ban on smoking. I do not understand this approach, especially when wishing to smoke is not unusual or unreasonable among psychiatric patients, and all the more so when the patient is not showing any violent aggression towards the staff, for example. Instead of permitting the patient to smoke regularly, records of his lapses continue to increase until he is finally placed in the isolation room for 13 days. During this time, the staff watches his protests, waiting for acknowledgement of fault and some kind of a guarantee from the patient and presuming what else could happen. This, in my opinion, is an abuse of means of restraint for disciplinary purposes, or rather punishment. **This was approved by 14 doctors.**
- The same holds true of the seven-day stay in the isolation room 4 days later. It is impermissible to use means of restraint against a patient as a punishment for a lack of self-control and for unwillingness to comply with an overly restrictive regime.

It has also been proven, in my opinion, that it was sometimes the nurses (not a doctor) who made the decision on placement in the isolation room in a situation where delay would have led to no additional risk, which is at variance with the law.

- On 21 September the nurses used the isolation room independently even during the working hours of the doctors in the ward. I do not draw any conclusions as to whether or not the previously administered anti-restlessness injection was a means of restraint; nevertheless, it is again problematic that the decision was not made by a doctor.

- On 26 November, the nurses used the isolation room independently during the ward rounds after learning that the patient had attempted to steal a detergent. I do not see any danger of delay in this situation.

In my opinion, by acting as described above, Psychiatric Hospital A as a health care services provider violated the law. This interference with fundamental human rights, in my opinion, exceeded the "minimum threshold of gravity", thus amounting to interference with the right not to be subjected to inhuman and degrading treatment.

C.2.8 Restrictive regime

Limitations may be placed on the fundamental rights and freedoms only by law (Art. 4 (2) of the Charter of Fundamental Rights and Freedoms). An assessment of interference with fundamental rights is to examine whether the interference was legal, pursued a legitimate goal and was proportionate.

The CPT standard on solitary confinement of prisoners lays down the following basic principles for a further restriction of the freedom of people deprived of their liberty: the measure must be **necessary** (for example, the restrictive regime must be flexible enough to permit relaxation of any restriction which is not necessary in individual cases); **proportionate** (to the existing or potential harm; the longer the measure lasts, the stronger must be the reason and the more must be done to ensure that it achieves its purpose); **lawful**; **accountable** (documented to a sufficient level of detail); **non-discriminatory**.[22]

Above, I described the regime to which Mr. A. has been subjected in the admission ward for about 10 months. It is very restrictive, comparable only with solitary confinement in a prison, but even harsher.

(1) The patient does not have direct access to a lavatory and depends on the willingness and time of the staff in the restlessness ward in this basic need.

(2) The patient is not allowed to go outside, not even for 1 hour per day, which is the minimum standard not only for the service of imprisonment, but according to the CPT, also for patients in psychiatric hospitals.[23]

(3) The patient is not allowed to smoke in spite of being a smoker and not having accepted abstinence even after several months. He is unjustifiably treated differently from other patients because the hospital has not created special conditions for his smoking, even though doing so is not impossible.

(4) Isolation with only a few other persons is not compensated by any special activities. In fact reading is the only activity available to the patient.

(5) The phone calls with his mother are not made in private.

22 CPT Standards, section Solitary confinement of prisoners [published in the 21st General Report CPT/Inf (2011) 28].

23 CPT report on the visit to the Czech Republic, CPT/Inf (2015) 18, para 155

(6) The patient is left with no room for self-determination and privacy: he wears pyjamas all the time, is allowed to have almost no items on him and is permanently monitored by cameras.

The patient's regime has not been reviewed or adjusted even when it became obvious that the goal pursued by the regime has not been achieved even after several weeks, that it is unbearable for the patient in some aspects and provokes him to further violations of the rules and non-observance of his obligations (especially in terms of smoking).

Violation of the strict regime alone is an aggravating circumstance for the patient – it is regarded as non-compliance with the individual treatment procedure[24] and results in application of restraints, including those imposed by way of punishment. The threat of preventive detention is imminent in this situation.

(7) Spending weeks in the isolation room became a part of the patient's regime. I am of the opinion that in acute psychiatric care, conditions of this kind would be addressed by observation.

In terms of legality of the measures applied, it is necessary to explain what restrictive regime measures are permissible in the context of the applicable legal regulations. A patient has the right to a proper professional standard of care, which includes a therapeutic regime as part of the individual treatment procedure; **thus, the therapeutic goal forms the basic framework for regime measures**. As a standard, this is limited by the patient's consent to the proposed individual treatment procedure and by other patient rights, including the right to health care services in the least possible limiting environment.[25] The law permits also some other reasons for imposing restraints, for example if essential to provide for **proper operation of the medical facility and other patients' rights** (statutory limits of the internal rules), as well as **quality and safety of the health care services provided**[26]. In protective treatment, the Specific Health Care Services Act allows the provider to go even further and impose specific prohibitions, rejections and checks (leave permits, correspondence, visits, telephone calls, body search and search of items), also taking account of the individual treatment procedure and goal of protective treatment. **Human rights limitations are subject to the legality and subsidiarity principle.**

In the case of Mr. A., even the strictest of measures could not achieve the set goal, i.e. preventing *any* lapse. It is not true that Mr. A. remains clean if he is completely isolated. The set objective is not realistic and is also not compatible with the goal of the protective treatment. The detention purpose continues in the protective treatment of Mr. A. He has spent half of his life in conditions of significantly restricted freedom simply because of failing repeatedly. In the court expert's opinion, his mental disorder is a permanent one, the symptoms being unstable and unpredictable mood, unpredictable variations in behaviour, explosiveness, impulsiveness, reduced frustration tolerance, maladaptivity,

24 Some records are indeed dramatic. XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX. However, nothing in the records suggests this.

25 "… in ensuring quality and safety of the health care services provided", Section 28 (3)(k) of the Health Care Services Act

26 ibid.

reduced threshold for venting aggression, inclination to rationalise his anti-social behaviour, manipulative conduct. The dependence on alcohol and psychoactive drugs results from a personality disorder.

Having lost its capability of achieving a legitimate goal, the regime no longer serves to treat the mental disorder. Many of the specific measures which, by their nature, represent limitations of human rights do not fall within an express legal authorisation under a special law and are not proportionate to the objective of ensuring safety and rights of other persons (wearing pyjamas all day, restricted access to a lavatory, ban on going outside and smoking, limited possession of personal items, telephone calls only in the presence of staff). Therefore, the regime has lost support in law and represents, in some aspects and also as a whole, unlawful infringement on the patient's rights.

In terms of intensity of a potential infringement, it has become a consistent rule in the interpretation of fundamental human rights [27] that a measure which is therapeutically necessary may not be regarded as inhuman or degrading treatment; however, the therapeutic necessity must be well established.

The patient did not succeed in initiating an independent review of his case and he does not see any hope for a change of his position in the hospital. He rightly feels helpless. The regime in question has elements of dehumanisation and the patient rightly feels inhumanely treated, isolated and humiliated.

While it would be possible to assess the individual decisions separately, I am evaluating the regime to which Mr. A. is subjected as a whole in terms of its duration and consequences. In my opinion, it represents unjustified interference with the patient's fundamental rights and has reached a level where it already qualifies as inhuman and degrading treatment.

C.2.9 Other aspects of the care provided

Given the foregoing, I can generally conclude that the patient has been consistently entrusted to a qualified therapeutic team of psychiatrists and nurses who pay considerable attention to him in the hospital. I did not examine whether any aspect, such as psychotherapy, is absent in the overall care provided. A professional assessment would be necessary for answering this question, which in my opinion is not necessary for the purposes of my inquiry.

The therapeutic team sufficiently documents its steps, notwithstanding the amount of work involved. Although I criticise, in several specific cases, unfounded and inappropriate evaluations in the records, I still consider that the records as a whole are kept properly.

27 Case law of the European Court of Human Rights, which has repeatedly ruled along the lines of the judgment in Herczegfalvy v. Austria of 24 September 1992 No. 10533/83. Jurisprudence has it that Article 3 of the Convention is violated when an involuntary medical act exceeds "legitimate treatment". BARTLETT, Peter, OLIVER, Lewis, OLIVER, Thorold. Mental Disability and the European Convention on Human Rights. Leiden: Martinus Nijhoff Publishers, 2007, p. 127.

A provider of health care services is obliged to provide for setting up, co-ordination and implementation of an individual treatment procedure, including proposed treatment.[28] Protective treatment is specific in that it is a measure which lasts as long as required by its purpose; however, the patient has a chance of regaining freedom through judicial review. This specific feature must be integrated in the proposed treatment (treatment procedure plan); the plan of care thus includes efforts to reduce the risk involved in the patient, monitoring of the progress on the path to release and verification of the patient's reliability. The medical team recorded Mr. A.'s epicrises including a plan of a further treatment procedure. The records described the relevant facts. Consequently, I have again no objections in formal terms.

The quality of the plan is, however, given by its contents. It is certainly appropriate that the therapeutic team concentrated on ensuring the patient does not become intoxicated. In my opinion, however, in order for the patient to be motivated, the plan must be achievable. Yet as far back as November 2015 the condition for releasing him from the admission bedroom was that the "patient is able to remain quiet, with no objectionable behaviour", and in June 2016 a transfer to ward R was conditional on three months without any violation of the admission bedroom regime, including the ban on smoking, which in fact does not belong in the individual treatment procedure under this type of protective treatment. It was impossible for the patient to comply with the plan, which was designed in a manner that was not necessary for achieving the purpose of the protective treatment. As the period of stay in the admission bedroom was extended, the plan contained no measures that would make up for the weight of this deprivation and pursue satisfaction of the patient's needs, including the basic ones.[29]

C.3 Complaint handling in the psychiatric hospital

(…)

C.4 Therapeutic relationship

Considering that the restrictions ceased to meet the criterion of legality, necessity and proportionality, they can be seen as arbitrary. However, I do not see any ill will behind them. It is often apparent from the records that the goal pursued was to protect the patient from any damage to health and death and to achieve a reasonable therapeutic goal (benzodiazepine profile).

The head doctor did not make the decisions on his own, although the patient and his mother saw him as the face of the decisions made. The entire medical team in the ward acted in concert. The therapeutic team often did not see any other solution and probably does not see one even now, because the conditions for a transfer to ward R as established in June 2016 are not realistic and in fact do not resolve the problem. However, this does not mean that there is no solution at all and that the hospital has no choice left. On the

28 Section 46 (1)(b) or Section 3 (3) of the Health Care Services Act

29 including as defined by the classical Maslow's hierarchy of needs

other hand, I believe that it is a therapeutic failure when efforts at motivating a patient are abandoned and a plan of care is generally reduced to isolation.[30]

Exhaustion of the therapeutic team can be an understandable consequence of the frustrating, never ending work with an unco-operative patient whose conduct is problematic and his mental disorder and experience from the past 20 years do not promise any significant improvement. Not to mention the very demanding work with patients in ward X as a whole. This applies to both psychiatrists and nursing staff in general.

The therapeutic team is also burdened with the **phenomenon of dual loyalty or dual role**. Specifically, a doctor assumes the caring role involving the duty to protect the doctor-patient therapeutic relationship, alongside with the role of an expert exercising protective treatment in public interest. These two roles can be contradictory and assuming them requires clarity and openness towards the patient as well as in introspection. In comparison with e.g. prisons, the provision of health care services in psychiatry is specific in that the authority which can decide on continuing restriction of freedom overlaps with the provision of health care services. A doctor has the power and duty to advise the court of a patient's failures, protect the patient from other patients, use means of restraint and other coercive instruments and administer medication without the patient's consent. The doctors felt this dilemma in Mr. A.'s case.

The lack of trust on the guardian's part and the patient's hostility are very obvious. The patient had been complaining to the management of the hospital about head doctor B. since November 2015, asking for his replacement. In May 2016 the guardian requested that Mr. A. be transferred from ward X. She pointed out that Mr. A. had been attacked and repeatedly stolen from there and neither of them had any confidence in MUDr. B., who allegedly bullied them. MUDr. B. is aware of the hostility; he endeavours to be impartial when dealing with the patient and his mother. They are often in contact.

The risk of disappearing confidence in the physician-patient relationship is inherent in disciplines where involuntary treatment is used. This burden, together with the phenomenon of dual loyalty, places special demands on **prevention and control of abuse of power**. Certain preventive strategies exist abroad, such as having the case reviewed by an independent expert in three-month intervals if it is a complicated case involving a long-term isolated patient (peer review). For means of restraint in general, the CPT Standards recommend obtaining an external opinion of an unbiased colleague if means of restraint are to be continued, and subjecting all cases to preventive inspection and evaluation. The Defender recommends keeping central records of the use of means of restraint and evaluating them at regular intervals. Ethics of the medical profession require that a

30 See the record from 14 March: "With the patient's case history, it makes absolutely no difference in the present situation whether he spends another year (two or five) in the bedroom; it is always ultimately his decision whether he gives in to his craving and indiscipline or wishes to proceed further in the therapy towards outings in the ward garden with his mother or even receiving leave permits."

therapist should be able to admit that he/she needs to consult the professional and ethical problems of a disease in a specific context with someone.[31]

In a large psychiatric hospital, the role of "external eyes" could be assumed by doctors from other departments who attend other wards at any rate when on standby duty. It should be noted, however, that this security element failed in this patient's case since 14 doctors were prepared to approve his stay in the isolation room which in fact was a punishment. According to the logics of all the doctors concerned, it is justified to submit a patient to means of restraint when the patient is negativistic and has a heavily psychopathic personality and when the patient's behaviour in the isolation room does not guarantee that the incidents will not reappear.

Some therapeutic relations become disrupted in practice; it is after all in the hands of all the parties involved. If this happens, it is necessary to **avoid adverse impacts** on the quality of the health care services provided. Assistance from an impartial person may suffice in some cases; in an extreme case the patient must be handed over to colleagues. It is in accordance with medical ethics to request that a patient be handed over to another doctor.[32] While it is not easy to hand over a patient in protective treatment to another provider of health care services in the Czech Republic, such cases exist, sometimes due to exhaustion of the parties involved.[33]

In conclusion, it should be noted that the therapeutic relationship between Mr. A. and the therapeutic team is seriously disrupted. I consider that it cannot be restored and an unbiased approach to the patient is not guaranteed in Psychiatric Hospital A. In future, if this problem occurs, it should be a standard for the psychiatric hospital to work on (a) prevention, (b) resolution of the problem.

C.5 Role and procedure of the hospital management

A provider is obliged to provide a proper standard of health care services, create conditions and measures for ensuring the exercise of the rights and duties of patients and other authorised persons, health care personnel and other professionals in providing health care services.[34] The law explicitly lists some specific measures through which a provider performs this duty.

Internal control measures include, for example, the duty to introduce a system for evaluating quality and safety of the health care services provided. Nevertheless, in the matters addressed by this report, it is only possible to rely on the recommendations of

31 PTÁČEK, Radek, BARTŮNĚK, Petr, *et al.*, p. 139

32 Section 2 (4) of the Code of Ethics of the Czech Medical Chamber: "A physician has the right to refuse to care for a patient for professional reasons or due to excess work or if the physician is convinced that the necessary confidentiality relationship between the physician and the patient has not been created. The physician is obliged to recommend and, if consent is granted, provide for an appropriate procedure in further treatment."

33 According to an expert consultant, one such situation is enabling a "blocked" client to become "restarted".

34 Section 45 (1) of the Health Care Services Act

bodies such as the CPT[35] and the Public Defender of Rights (see above) and hence progressiveness and priorities of the management.

I believe that the therapeutic team's decisions in Psychiatric Hospital A are normally not subject to any control unless they involve an application lodged with the court. **Continued application of means of restraint and the admission bedroom regime are not subject to any systematic control, which I regard as an error that should be remedied in the future.** Such control can operate as a safeguard ensuring that the provider's management is activated in sensitive matters as a counterweight to the therapeutic team.

In the case of Mr. A., however, the management has a thorough knowledge of his situation and has played an active role in looking for a solution. The hospital offered to address the situation by "transferring" the patient to another psychiatric hospital (this possibility was on the table already in September 2015 and undoubtedly existed also in May 2016).

I criticise the fact that despite the detailed awareness of the case, the management failed to prevent further tightening of the regime, prolonged use of the isolation room and provision of care in a seriously disrupted therapeutic relationship. This condition continues to date, due to the unrealistic plan from June 2016. (...)

I must also criticise the management of the hospital for failing to implement the previous recommendations of the Defender, XXXXXXXXXXXXXXXXXXXXXXXX, especially failing to ensure the possibility of daily outings to all patients in protective treatment.

C.6 Protection against ill-treatment and effective remedy

C.6.1 Legislation

The prohibition of torture and ill-treatment gives rise to **"positive" obligations of the State**, i.e. the State's obligation to ensure or do something. This includes, for example, the obligation to ensure that persons held in detention, and hence fully in the State's power, are held in conditions that are in compliance with the requirements following from Article 3 of the Convention (this concerns the conditions of accommodation and daytime activities, food, solitary confinement). Requirements for human conditions of detention are applied notwithstanding the reason and location of the detention.[36]

Any person whose human rights and freedoms have been violated has the right to an **effective remedy**. In the context of restrictions of personal freedom, such a remedy must be independent of the public authorities responsible for the facility in question, must ensure the complainant is effectively involved in addressing the complaint, ensure the complaint is addressed quickly and thoroughly and involve legal means to avoid the problem which led to the submission of the complaint.[37] In the context of conditions in

35 According to the CPT Standards, "an active and alert role by management with respect to resort to means of restraint in a given establishment has usually resulted in a steady decline in their use".

36 Kmec, J., Kosař, D., Kratochvíl, J., Bobek, M. Evropská úmluva o lidských právech. Komentář. (*European Convention on Human Rights. Commentary).* 1st edition. Prague: C. H. Beck 2012, p. 419.

37 Article 13 of the Convention for the Protection of Human Rights and Fundamental Freedoms in light of the case-law of the European Court of Human Rights.

prison facilities, a court inferred that a **preventive remedy** must be available to a person in a situation when examination is being carried out as to whether or not the conditions in which the person stays are in accordance with Article 3 of the Convention; the remedy must be capable of promptly putting an end to the wrongful state of affairs.[38]

A special approach must be taken in the protection of **vulnerable groups**, such as persons with mental illnesses, persons restricted in their freedom and involuntarily hospitalised patients.[39]

C.6.2 Complaints in the psychiatric hospital

A patient or his/her guardian may lodge a complaint against the procedure of a provider in the provision of health care services; the complaint is lodged with the provider against which it is addressed and subsequently, if required, to the competent administrative authority (in this case the Regional Authority). A provider does not act as an independent body in handling the complaint but rather as an agent of public power exercising protective treatment. A provider can promptly ensure remedy. Complaints were not addressed properly and did not bring remedy in the case of Mr. A.

C.6.3 Criminal complaint

In the area of health care, criminal punishment of ill-treatment is an extremely complicated topic; nevertheless, in very simple terms, the criminal prosecution bodies should pursue (and initiate) investigation as soon as they have sufficient evidence that ill-treatment may have occurred in relation to patients in a particularly vulnerable position. A necessary condition is that there is a well-founded assertion contained in the criminal complaint or even in an appeal in court proceedings.[40]

I am clearly not able to assess the protection the Police provided, or could have provided, to Mr. A. The Police investigation took place before Mr A.'s third and fourth stay in the isolation room, during the 6 months when he was subjected to a very strict regime. The procedure of the Police is supervised by the State Attorney to whom a complainant can turn at any time.

C.6.4 Complaint sent to the court

The competent court ruled that it "lacked any power to interfere in the treatment procedures of Psychiatric Hospital A".

C.6.5 Limits of a complaint lodged by the patient

It should be said that Mr. A.'s conduct, personality and past may undermine his credibility in the eyes of external parties: He has been constantly raising demands since August 2015, in manners that confirm his diagnosis. It is not easy to interpret his complaints, in terms of

38 judgment in Ananyev and others v. Russia of 10 January 2012, No. 42525/07 and 60800/08

39 M. S. v. Croatia (No. 2), para 96–98

40 M. S. v. Croatia (No. 2), para 74 *et seq*.

whether he primarily aims to be transferred to an out-patient treatment, freed from the influence of head doctor B. or subjected to a more relaxed regime including leave permits for visiting home. He was sending criminal complaints to all sides; he withdrew his application for the initiation of court proceedings. He does not fully understand the seriousness of his ill-conduct in the hospital. For the entire time of the protective treatment, he will be restricted in his freedom due to having committed a serious criminal act. Nevertheless, all the foregoing elements are typical, and the risk of trivialisation is one of the reasons why special protection should be extended to persons vulnerable on grounds of a mental disorder who are restricted in their freedom.

The potentiality of the protective treatment being transformed into preventive detention, which has been discussed since 2015, deters the patient's guardian from taking a more active approach. There is reason to believe that she feels intimidated also by the conduct of the hospital representatives (see the head doctor's record of the telephone conversation of 17 May and MUDr. Ž.'s note of 1 June 2016).

C.6.6 Summary

Preventive internal control at the provider, to the extent that it is in place, has not played a role in the case. The internal control at the health care services provider activated by the complaints lodged by the patient and his guardian did not result in detection and remedy of the shortcomings, and later ill-treatment.

While internal control is potentially the promptest means of ensuring remedy, it lacks independence. In terms of external control, it essentially does not exist in the Czech Republic in the sense of prevention, with the exception of the "soft" powers of the Public Defender of Rights.[41] In terms of review of the case at hand, the patient turned to the Police and courts, i.e. parties completely independent of the provider of health care services. The Police closed the case very soon without initiating criminal proceedings; the court declared that it lacked competence to review the treatment of the patient. Thus, the patient did not receive any protection.

In my opinion, this is an illustrative example of a gap in the system of protection of fundamental rights in the Czech Republic. The only measure available consists in criminal punishment of ill-treatment (which, in the present legal state of affairs, is not applicable in many situations in the area of health care services). No truly effective intervention is available, whether *ex officio* or based on an application that does not involve a procedure exceeding the abilities of a lay person, let alone one in a position of high vulnerability (I am referring to the theoretical possibility of bringing an action against unlawful intervention by an administrative authority together with an application for preliminary injunction).

41 The State Attorney's Office does not perform supervision over observance of legal regulations in places where restriction of freedom occurs in psychiatric hospitals. Preventive inspection activities of the Regional Authorities do not fully meet the independence criterion and are essentially absent: the Public Defender of Rights has found that Regional Authorities did not perform a single inspection concerning the use of means of restraint over a period of two and a half years (overall, not just in psychiatric hospitals). In the same period, the Regional Authorities performed three inspections focusing on treatment (including therapeutic) in psychiatric hospitals, not finding any single shortcoming; Report on the Public Defender of Right's Research of 24 March 2015, File No. 22/2014/NZ, available at: http://eso.ochrance.cz/Nalezene/Edit/3670.

There is clearly no mechanism available in the area of protective treatment that would fulfil the obligations following from Article 13 in conjunction with Article 3 of the Convention for the Protection of Human Rights and Fundamental Freedoms.

C.6.7 Institutional guarantees ensuring a patient is not subject to ill-treatment

As noted above, the State has the obligation to ensure that persons confined in protective institutional treatment are held in conditions compliant with the requirements following from the prohibition of ill-treatment. **Independent preventive control**, such as that established e.g. in the prison system through the State Attorney's supervision, is an effective instrument for fulfilment of this obligation – assumed on an international forum. In my opinion, the case of Mr. A., as well as the previous inquiries of the Defender, which did not lead to remedy, clearly show that such control is essential also in a psychiatric hospital, at least so far as patients in long-term detention and patients with a strict regime are concerned. Persons restricted in their freedom can be held in unadjusted conditions (in the case in question the patient did not have access to toilet and could not get outside) and in social isolation also in psychiatric hospitals. This is accompanied by the problem of long-term use of means of restrain and a regime interfering with fundamental rights and freedoms, in respect of which the doctor has a very broad discretion in terms of therapeutic necessity. On account of their increased vulnerability, these patients may be unable or unwilling to complain.

C.7 Resolution of the case

It is the obligation of governmental authorities to prevent imminent ill-treatment and put an end to an existing ill-treatment of which they are, or ought to be, aware.[42] Consequently, it is necessary to take remedial measures without delay.

What happened in 2015 and 2016 is an irreversible development characterised by worsened relations and non-observance of the treatment regime by the patient. Regardless of who is correct regarding the causes, it seems obvious that restoring the regime that existed prior to 23 July 2015, including the leave permits, is now impossible.

In my assessment of the case, I contested the presented conditions for a transfer to ward H. Since autumn 2015 the therapeutic actions concentrated on the endeavour to keep Mr. A. "clean" by isolating him, with several failed attempts at relaxing the regime. In the opinion of the therapeutic team, the March 2016 experience has shown that Mr. A. will fail when placed among other patients and remains clean when kept in the admission bedroom. However, the situation is not this clear. The regime and the admission bedroom have proven insufficient several times. The consequences of the repeated failures fell on the patient alone, despite the fact that the facility actually has a duty to ensure safe conditions when a person is restricted in his or her freedom (see the persisting trading of medication) and to minimise the necessary restriction of the patient's rights in order to avoid excessive harshness that could contribute to the patient's ill-conduct.

42 Judgment of the Grand Chamber in Osman v. the United Kingdom of 28 October 1998, No. 23452/94, para 116, and in other case law of the European Union also in respect of Article 3 of the Convention; Ananyev v. Russia, para 97-98

My proposal is that the situation should be approached as a crisis and a realistic plan of further procedure should be determined among the parties involved.

D. Conclusions

Psychiatric Hospital A. erred in that:

- it submitted a patient in protective treatment to ill-treatment consisting in illegitimately placing the patient in the isolation room for 10, 13 and 7 days and holding him in an inadmissibly strict regime for several months;
- the decision to place the patient in the isolation room was made by the nurses (not the doctor), even in situations where delay would have led to no additional risk;
- the hospital did not handle properly the complaints of the patient and his guardian.

I have also found the following errors:

- conditions in ward X that do not meet the standard of a therapeutic environment for a long-term stay of patients;
- systematic internal control of the use of means of restraint and long-term holding in the admission bedroom regime is missing.

I am sending this report to the director of the hospital and, pursuant to Section 18 (1) of the Public Defender of Rights Act, I request that he respond to the found errors within 30 days of its delivery and inform me of the remedial measures he adopted. The report summarises my current findings, which may be reflected in my final opinion under Section 18 (2) of the Public Defender of Rights Act.

For the time being I am not sending the report in its present form to the complainant and his guardian. I am merely informing them of my findings and conclusions and will provide the report to them later, following the hospital's further steps.

In Brno, on 9 September 2016

Mgr. Anna Šabatová, Ph.D.
Public Defender of Rights