Public Defender of Rights
OMBUDSMAN

Report from Systematic Visits to

SOBERING-UP STATIONS

2014

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Introduction

1.1 Legal basis of the systematic visits

Based on the provisions in Section 1 (3) and (4) of Act No. 349/1999 Coll., on the Public Defender of Rights, as amended, the Public Defender of Rights carries out systematic visits to places (facilities) where persons restricted in their freedom are or may be present. The cause of the restriction may either be the decision of a public authority or it may result from dependence on the care provided.

The Public Defender of Rights has been carrying out systematic visits since 2006. The information on the generalised findings concerning the situation in the individual types of facilities is released to the public.

The aim of the systematic visits is to strengthen the protection of persons against all forms of ill-treatment.

1.2 Systematic visits to sobering-up stations

In 2013 and 2014, the Defender's choice for systematic visits fell on sobering-up stations (drunk tanks) as health care facilities in the sense of Section 17 of Act No. 379/2005 Coll., on measures for protection against harm caused by tobacco products, alcohol and other dependency producing substances, as amended.

Pursuant to the definition laid down in Act No. 379/2005 Coll., sobering-up stations serve for detention of persons who cannot control their behaviour due to the influence of alcohol or other dependency producing substance and thus directly endanger themselves or other persons, public policy or property, or they are in a condition causing public nuisance.[1] The detained must submit to treatment and remain at the station for a period long enough for the acute intoxication to subside, regardless of whether they have given consent to it or not. Sobering-up stations are places where personal freedom is restricted in the sense of Article 8 of the Charter of Fundamental Rights and Freedoms and Article 5 of the Convention for the Protection of Human Rights and Fundamental Freedoms[2] and, as such, they are subject to the Defender's supervision.

The reason why the Defender chose to include this type of facilities in her programme of visits comprised, on the one hand, the individual complaints she had received in respect of detention in sobering-up stations and, on the other hand, the insufficient domestic regulation of this area, which has been put into question by case law of the European Court of Human Rights.[3]

1.3 Course of the visits

The systematic visits are usually unannounced, but they are carried out on site with the knowledge of the facility management. Each visit to a sobering-up station lasted one day and consisted of inspection of the areas where the detained persons were staying, interviews

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1 Section 17 (2) of Act No. 379/2005 Coll.

2 Memorandum of the Federal Ministry of Foreign Affairs No. 209/1992 Coll., on the Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by protocols No. 3, 5 and 8.

3 ECtHR judgement in case Witold Litwa v. Poland of 4 April 2000, no. 26629/95, ECtHR judgement in case Wiktorko v. Poland of 31 March 2009, no. 14612/02, ECtHR judgement in case Bureš v. the Czech Republic of 18 October 2012, no. 37679/08.

with the personnel present, study of the facility's internal regulations, and inspection of the medical records of the detainees. Photographic evidence was taken during the visits.

The reports on the visits reflecting my findings and including my recommendations and measures, if any, to increase the standard of the care provided were sent to the management of the individual facilities. The management in all sobering-up stations I visited have issued statements on my reports and informed me of the measures adopted.

1.4 Information on the facilities visited

Employees of the Office of the Public Defender of Rights visited 6 sobering-up stations of the total number of 18 such stations currently in operation in the Czech Republic (i.e. a third of all these facilities). Three of the stations visited are operated as part of regional hospitals, one falls under a hospital founded by a statutory city. Further stations fall under the regional medical rescue services (i.e. founded by the Regions). One station founded and operated by a private person was also visited.

Most of the stations visited are operated as part of another health care facility and are based directly on its premises. One station is situated outside the immediate vicinity of any other health care facility.

The stations visited usually contained several rooms with multiple beds (single bedrooms were an exception), an examination room for admission of detainees (sometimes also a changing room) and sanitary conveniences (usually including a shower). The detainees were always locked in their rooms. The rooms were furnished with beds (or mattresses on the floor, as seen in one of the stations) and a toilet (usually a squat toilet) placed in the corner. Aside from the above, the detainees were further only provided with bed linen and a container with water.

Most stations use breathalysers to establish the degree of intoxication, only 4 of the stations visited also offered the possibility of blood tests for the presence of a dependency producing substance (at police request, if intoxication by substances other than alcohol is suspected). Aside from the care provided to the detainees, two of the visited stations carry out medical examinations for the police to establish the degree of intoxication by alcohol or other dependency producing substances.

Further details on the facilities visited, including their capacities and the number of detainees per year are included in the table below.

Sobering-up station	Operator	Founder	Capacity	Number of persons admitted (2012)
Karviná	Medical Emergency Service of the Moravian-Silesian Region	Moravian-Silesian Region	13	2,057
Kroměříž	Kroměřížská nemocnice, a. s. (Kroměříž hospital)	Zlín Region	5	789
Liberec	Krajská nemocnice Liberec, a.	Liberec Region	10	–[4]

[4] The station in Liberec did not become operational until the end of 2012. According to available data, 620 persons were placed in the station in 2013.

	s. (Liberec hospital)			
Plzeň	Městská poliklinika Plzeň, spol. s r. o. (Municipal polyclinic in Plzeň)	private entity	10	1,740
Prague	Prague City Polyclinic	the Capital City of Prague	20	9,336
Ostrava	Ostrava City Hospital, contributory organisation	Statutory City of Ostrava	8	2,049

Summary of Findings

(1) Pursuant to the law, the decision on detaining a person in a sobering-up station and the resulting **restriction of his or her personal freedom** is a responsibility of the health care services provider. However, the staff in most of the stations visited were not aware of this responsibility; the medical workers usually considered the police (which brought the detainee to the station) to be the responsible body. In all the stations visited, I encountered cases where it was not possible to unambiguously establish, on the basis of the documentation, whether or not the statutory conditions for the detention of the person in the station had been met. I criticised mainly the insufficient records of whether or not the detainee *"immediately endangered him/herself or other persons, public order, or property"*. I noted the fact that the mere *"causing of public nuisance"* cannot justify restriction of a person's freedom and should thus be removed from the wording of the relevant law.

(2) The stations have a statutory **notification duty** with respect to persons mentioned by the law (general practitioners, legal representatives, and guardians). None of the stations visited have fully complied with this duty; I have found shortcomings mainly in the area of compliance with the duty to inform the detainees' general practitioners. I consider the current legal regulation of the notification duty questionable and hard to comply with in practice; therefore I recommended its change.

(3) A key issue with operation of a sobering-up station service is the matter of **providing for the safety of the detainees** and the station's staff. Threatening behaviour indicates the need for placement in the station as the detainees often cannot control what they are doing. Nevertheless, in most cases they are placed in rooms with multiple beds. According to my findings, safety risks involve especially the inability of the staff to react quickly to aggression on the part of the detainees. The low "capacity to act" on the part of the staff, which I observed in the vast majority of the stations visited, resulted mostly from an insufficient number of employees, the majority-female composition of the staff, and the lack of training in handling of aggressive persons. In most of the stations visited, the staff rely on police assistance to deal with aggressive patients.

(4) Rooms in all the visited sobering-up stations are equipped with CCTV cameras to ensure safety, where the video feed is displayed on monitors in the nurses' station. However, in none of the sobering-up stations there is a call button that the detainees could use to call in the staff in case of emergency. Only one of the stations visited was equipped with an isolation room where aggressive persons could be isolated from others.

(5) **Restrictive measures** (especially physical restraints and sedation) are used in sobering-up stations to handle aggressive detainees. In some of the stations, the staff members were not sufficiently informed as to what constitutes a restrictive measure and what the legal requirements for its use are. In two of the stations, I encountered the lack of awareness on the part of the staff that the use of physical restraints or sedatives constituted a restrictive measure. In some of the stations, there also was no internal regulation of its use. The lack of awareness of the legal regulation and the

insufficiency of the internal regulations resulted, in some of the stations, in serious shortcomings in the use of restrictive measures (unauthorised use of restrictive measures, insufficient supervision of persons subjected to restriction, order to use a restrictive measure given by an unauthorised person, excessive duration of restriction and gaps in the documentation).

(6) The employees of the Office were interested in detailed inspection of the documentation of the reasons for use of restrictive measures. In 18 out of the total of 31 randomly selected observed cases of use of restrictive measures (58 %), I concluded that the reasons for the use of restrictive measures were insufficiently documented and it was thus impossible to verify the lawfulness of restriction. In one of the stations, I even concluded that, provided that the fragmented records contained in the documentation were accurate, the use of restrictive measures was at variance with the law. This represents a serious violation of the law and a possible infringement of the patients' rights.

(7) In half of the stations visited, cases were observed where the restriction (cuffing) lasted for several hours, without it being clear whether the reason for restriction continued. In 10 of the 23 randomly observed cases, the duration of restriction was longer than 3 hours (43 %), and in 6 of those the duration exceeded 6 hours (26 %). In most of the cases, the documentation did not indicate sufficient supervision of the restrained patients. Neither the interval nor scope of the checks was indicated in the records. This again represents a serious violation of the law and a possible infringement of the patients' rights.

(8) In five of the stations visited, sedatives were used as a measure restricting the movement of detainees. In some of the stations, the staff was reluctant to administer sedatives, while in other this measure was used very often. In one station, sedatives represent the only measure used to calm aggressive persons. I noted that in the experts' opinion, the administration of any kind of psychoactive medication to an intoxicated person may be dangerous and potentially life threatening. The physician should thus prefer physical restraints over sedatives.

(9) Pursuant to the law, only a physician may decide on admission and release of detainees in a sobering-up station. Only a physician may decide to use restrictive measures; the nurse may do so only under extraordinary circumstances and in cases of emergency (in that case, a physician has to later approve the decision). In most of the stations visited, a physician is not present during the whole operating hours; in five stations, a physician is always available on call. In one independently situated station, no physician was available at certain time of day (not even on call) and the station was operated solely by nurses, including admission and release of detainees and decision-making concerning the use of restrictive measures. It was found that in two other stations, a nurse on her own was making decisions on release of the detainees, although a physician was available at the station. It is inadmissible for **medical personnel to overstep their competences in such a manner** and it is the responsibility of the health care services provider to ensure this does not occur.

(10) None of the stations visited sufficiently provided for the **privacy of the detainees** during toilet use. In five of the stations, the toilets in rooms with multiple beds were not sufficiently separated from the rest of the room, and were furthermore under CCTV surveillance. In one of the stations, a toilet was not available in the room at all and the detained person had to urinate, in plain sight of the other detainees, into a bucket, or call in the staff (without any call button). In half of the stations visited, privacy was likewise not ensured during the admission procedure, which consists of a medical examination, changing of clothes and, if necessary, showering the detainee, since the police were always present at these tasks. The casual presence of a police officer and the above-described lack of privacy standard in the rooms is, in my opinion, inadmissible.

(11) The stay and the examination and treatment in the sobering-up station are paid for by means of a **direct fee**. The amount of fee varies greatly among the stations (from CZK 600 to CZK 4,300) since neither a concrete amount of fee for stay nor the method of its calculation is set by legal regulations. As the clients of the sobering-up stations are mostly poor, only about 15 to 30 % of the detainees actually pay the fee. I note that subjecting the provision of basic health care services to a direct fee is at variance with the constitutional right to free health care. The system of payments for the sobering-up station services is insufficiently regulated (also with respect to the protection of the rights of the detainees) and represents a great financial burden both for the operators and the founders of the stations.

Summary of Recommendations

Recommendations for the Ministry of Health:

- set up, through legal regulation, minimum requirements for the personnel and material and technical equipment of sobering-up stations; in drafting the text of the regulation, take note of the recommendations contained in this report (Chapter 4.2);
- initiate a change of the law in the sense that the mere *"causing of public nuisance"* is no longer a sufficient reason for detaining a person in a sobering-up station (Chapter 5.1.1);
- initiate a change of the legislation regulating the detention of persons in sobering-up stations so that the wording of the law incorporates the principle that detention in a sobering-up station represents an extreme solution, which may only be used when other, less severe options are exhausted (Chapter 5.1.2);
- initiate a change of legislation to explicitly incorporate the duty of the physician who makes decisions on detention in the sobering-up station to make records of the behaviour of the patient after admission in order to ensure transparency with respect to the causes of detention (Chapter 5.2.3);
- Initiate a change of legislation in order to ensure that a person who, pursuant to Section 16 of Act No. 379/2005 Coll., initiates detention of a patient in a sobering-up station has the duty to co-operate with the station physician with respect to decision-making on detention, in the form of a written justified record of the situation which has led up to the initiation of detention in a sobering-up station, and of the reasons why less severe options have not been sufficient to deal with the situation (Chapter 5.2.4);
- consider and initiate a change of legislation on the notification duty in terms of the duty to notify the registering health care services provider in the area of general medicine (Chapter 5.5.2);
- initiate a change of legislation to incorporate the duty of the medical personnel at sobering-up stations (and in other health care facilities where the use of restrictive measures may be expected) to receive training in the use of restricting measures and its statutory requirements; for this purpose, provide for a training programme and guarantee its contents (Chapter 7.1);
- initiate a change of legislation to incorporate the principle of subsidiarity governing the use of restrictive measures in the Health Care Services Act (Chapter 7.2.2);
- initiate a change of legislation to incorporate the duty of sobering-up stations (and other health care facilities) to keep central records of the use of restrictive measures and to evaluate it (Chapter 7.7);
- initiate a change of legislation to ensure that direct fees are not used to pay for services falling under basic health care (examination and treatment of a person in the station) (Chapter 11.1);
- initiate a change of legislation to make sure the law clearly sets the amount of fee for the stay in the station, or at least the method of its calculation (Chapter 11.2).

Recommendations for sobering-up stations:

- in a specific case, always demonstrably consider whether or not there are other, less severe options than detention in the sobering-up station (e.g. entrust the person to the care of a close person, have the person taken home, etc.) and make use of these options, or insist on their use (Chapter 5.1.2);
- in cases where the clinical examination of the admitted person does not clearly show that the statutory condition of intoxication with alcohol or another dependency producing substance has been met (where the other conditions seem to have been met), carry out a breathalyser test or blood test of the admitted person (Chapter 5.2.2);
- advise the medical staff of all the statutory conditions for detention of persons in sobering-up stations and the responsibility for their examination (Chapter 5.2.3);
- concerning persons being admitted, examine not only their medical conditions and the degree of intoxication, but also whether or not their behaviour endangers themselves or other persons, public policy or property; ensure evidence this was the case (Chapter 5.2.3);
- reflect this examination in the records so that it is transparent which facts led the physician to decide on the admission of the person to the station (Chapter 5.2.3);
- ensure that the detainee is allowed to leave the facility when acute intoxication subsides (Chapter 5.3);
- co-operate with the police in order to prevent delays between the statutory time of release of the detainee from the station and his or her transfer to the police (Chapter 5.3);
- comply with the notification duty laid down by Section 17 (5) of Act No. 379/2005 Coll. and Section 105 (1) of the Civil Code; if the duty cannot be complied with due to the lack of co-operation on the part of the detainee, record the fact, including reasons, in the documentation (Chapter 5.5.1);
- ensure that the staff is always ready to intervene in case of aggression or agitation on the part of the detainee, including the use of restrictive measures in the sense of the Health Care Services Act (Chapter 6.1);
- ensure that there are sufficient personnel serving at the station (Chapter 6.1);
- ensure that there are sufficient male personnel serving at the station (Chapter 6.1);
- ensure that the staff are trained in using safe and sensitive physical measures against aggressive and otherwise agitated individuals (Chapter 6.1);
- prepare (set aside) a special room or several rooms for temporary isolation of high-risk individuals (Chapter 6.2.1);
- install call buttons in rooms where the patients are staying, enabling the detainees to call in the staff (Chapter 6.2.2);
- advise the staff on what constitutes a restrictive measure and what the statutory conditions are for its use (in the sense of Section 39 of the Health Care Services Act) (Chapter 7.1);
- provide the station with internal regulations for the use of restrictive measures that are in compliance with the Health Care Services Act (Chapter 7.1);
- ensure that restrictive measures are only used under circumstances anticipated by Section 39 (2) of the Health Care Services Act, i.e. only if the purpose of their use is to prevent an immediate threat to life, health or safety of the patient or of other persons (Chapter 7.2.1);
- when documenting the reason and the purpose of the use of restrictive measures, describe the specific behaviour of the detainee in order to enable assessment of the situation and the justification of the use of restriction (Chapter 7.2.1);
- use restrictive measures only when other, more sensitive procedures to calm down the detainee have been exhausted (Chapter 7.2.2);
- ensure that the staff always examines that the reasons for restriction continue, otherwise immediately stop applying the given restrictive measure (Chapter 7.3);

- ensure that the evaluation that the reasons for restriction continue is transparently recorded in the documentation (Chapter 7.3);
- ensure that decision-making on the use of restrictive measures complies with Section 39 (3)(d) of the Health Care Services Act (Chapter 7.4);
- ensure that a nurse does not make decisions on the use of restrictive measures, except in extraordinary and emergency cases. If the nurse decides to use a restrictive measure, a physician needs to be informed of this without delay and must approve the decision at the station in person (Chapter 7.4);
- ensure (through internal regulations and physician's decisions) suitable intervals and scope of check-ups of patients subjected to movement restrictions; the interval must be indicated in the medical records and the staff must respect it (Chapter 7.5);
- keep records of the use of restrictive measures pursuant to the Decree on Medical Records. I call attention especially to the need to unambiguously document the reasons leading up to the use of restrictive measures (Chapter 7.6);
- keep central records of the use of restrictive measures and evaluate them at regular intervals (Chapter 7.7);
- ensure that the patient subjected to restrictive measures remains out of sight and out of touch of other detainees (Chapter 7.8);
- prefer mechanical restrictions of movement over the administration of sedatives (Chapter 7.9);
- if sedatives are used, this must be convincingly justified and the reasons must be included in the records (Chapter 7.9);
- discontinue the use of cage beds (Chapter 7.10);
- ensure that a physician is available (or at least on call) during the whole operating hours of the station (Chapter 8.1);
- ensure such a composition of the staff which makes it possible to deal with potential crisis situations, which may sometimes occur due to the kind of clients present in sobering-up stations (Chapter 8.2);
- ensure that the medical personnel do not overstep their competences (Chapter 8.3);
- ensure that only a physician decides on admission, transfer, and release of the detainees (Chapter 8.3);
- ensure privacy for the detainees during toilet use so that they remain out of sight of the other detainees and the station staff (Chapter 9.1);
- ensure that the detainees have direct access to the toilet (Chapter 9.1);
- ensure that police officers stay out of the admission room and are present only if this is absolutely necessary and when the staff explicitly ask for them to be present (Chapter 9.2);
- allow the detainees to take a shower (Chapter 10).

Recommendation for the stations to improve the standard of care:

- equip the staff with signalling equipment so that they can raise alarm and call in help in case of emergency (Chapter 6.2.2).

Recommendation to persons who bring in the patients:

- in each specific case, always demonstrably consider whether or not there are other, less severe options than detention in the sobering-up station (e.g. entrust the person to the care of a close person, have the person taken home, etc.) and make use of these options, or insist on their use (Chapter 5.1.2).

Recommendation to the Regional Authorities:

- carry out regular inspections of sobering-up stations (as well as other health care services providers), especially with respect to compliance with the statutory conditions for use of restrictive measures (Chapter 7.1).

Conclusion

Acute intoxication with alcohol or other dependency producing substances may affect a person's mental state (cognition, emotions, wilful conduct, aggression) and represent a significant health risk. Therefore, the facilities which provide care to the acutely intoxicated must be ready to deal with both the aforementioned dimensions of this issue. In practice, this means for them to be able to examine the medical condition of the detainee and provide him or her with appropriate health care, but also to deal with the detained person's agitation or aggression in order to ensure this person's safety as well as the safety of the other detainees. The current model of the sobering-up stations service prioritises medical concerns over security concerns. This is due to the traditional concept of sobering-up stations as health care facilities run by medical personnel. I believe that this concept is well-grounded as the health risks associated with acute intoxication are beyond doubt. However, safety concerns cannot be ignored.

The systematic visits demonstrated that ensuring safety is indeed one of the key challenges of operating sobering-up stations. This issue is closely associated with the matter of ensuring sufficient staff for the operation of the stations and the composition of the staff, as well as their material and technical equipment (signalling equipment, isolation rooms). The shortcomings and significant differences in personnel and material equipment of the individual stations I found during my visits are, to a large degree, a result of the lack of regulation and the ambiguous legal basis for the sobering-up stations service. The legislation stipulates the duty to provide sobering-up stations, but it does not say how this is to be achieved; therefore, often only the minimum necessary requirements are met. These shortcomings significantly affect the treatment of the detainees and may result in unauthorised infringement of their fundamental rights. I believe that my findings included in this report are reflected in the anticipated legislative changes concerning sobering-up stations.

The use of restrictive measures is inseparable from the issue of safety. Indeed, restrictive measures may be used excessively and without authorisation in cases where the station lacks material and personnel means to deal with the intoxicated persons' behaviour. My findings show that the practice concerning the use of restrictive measures in many sobering-up stations is far from satisfactory and shortcomings in this area were found at all the stations visited. The use of restrictive measures represents both a significant infringement of the individual's fundamental rights and a substantial health risk (regardless of whether restriction is achieved using medication or physical means) and, as such, must be subject to strict rules. According to my findings, the current practice in use of restrictive measures practically excludes the possibility of review. Although the current legislation is relatively detailed with respect to the use of restrictive measures, the law still lacks certain important guarantees such as the principle of subsidiarity in using restrictive measures or the duty to keep central records of the use of restrictive measures. It is up to the legislators to fill in this gap and thus ensure the protection of rights of persons detained in sobering-up stations (but also in other forms of health care detention).

I am aware of the challenges which the provision of sobering-up stations service currently poses, including the high costs of operating the stations, and of the fact that the sobering-up stations no longer fulfil their original purpose of treatment and prevention. On the other hand, I also believe that in the current climate (where there is no suitable alternative as to where to place intoxicated individuals), the stations significantly contribute to the overall protection of health and lives of the intoxicated persons and others. The operation of these facilities would be impossible without the devotion and sacrifices on the part of their staff, for which they deserve much praise.

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