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The Seimas Ombudsmen's Office

2014-2015

REPORT ON NATIONAL PREVENTION OF TORTURE

Contents

Introduction

On 3 December 2013, the Seimas of the Republic of Lithuania ratified the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) and designated the Seimas Ombudsmen's Office as the national preventive mechanism.

Amendments to the Law on the Seimas Ombudsmen were adopted giving the mandate to the Seimas Ombudsmen's Office to implement the national prevention of torture by regularly visiting places of detention. Respective provisions of the said laws entered into force as from 20 January 2014. Therefore, 2014 was the first year when the Seimas Ombudsmen implemented the preventive mandate.

It should be noted that even though the OPCAT became active and the implementation of the national prevention of torture under the protocol started only from January 2014, monitoring of the situation of human rights in places of detention commenced already back in 2011. During years of 2011-2013, 14 inspections of places of detention were carried out.

These investigations convinced us that preventive activities against torture and other violations of human rights are necessary and create positive results, including the attention of institutions garnered to possible problems and aspects which could lead to breaches of the rights of detained persons. Also, a progressive and respectful attitude is promoted, with the view to achieving the long-term goal, namely to ensure that the rights of individuals held in places of detention are not violated.

The new mandate appeared to be a visit-intensive task. In a small country Lithuania, where the population does not reach 3 million, there are around 450 places of detention. Visits are planned with due regard to the number of institutions of different nature (social care and psychiatric institutions, police custody facilities and premises of temporary detention, incarceration institutions, children's socialisation centres, institutions of detention and accommodation of foreigners). In two years over 85 visits were carried out.

This Report gives a presentation on preventive work for the first biennium of the preventive mandate, 2014 and 2015. It overviews the structure of the national preventive mechanism, its powers, the methodology of inspections of places of detention, the outline of the investigations carried out, the most significant systemic problems identified, recommendations provided, cooperation between the Seimas Ombudsmen and Lithuanian as well as international institutions and NGOs, and other activities.

Powers of the national preventive mechanism

When implementing the national prevention of torture, the Seimas Ombudsmen enjoy extensive powers, namely they have the right to choose which places of detention to visit and which persons to interview, to enter all places of detention and their premises and to have access to their installations and facilities. The Seimas Ombudsmen also have the right to have private interviews with the persons deprived of their liberty without witnesses, as well as with any other persons who may supply relevant information, and to conduct inspections of places of detention together with selected experts. Inspections are organised to any place where persons are or may be deprived of their liberty, i.e. police custody facilities, imprisonment, care and mental institutions, institutions for treatment of infectious diseases, institutions for holding or accommodating foreigners and other institutions.

The Seimas Ombudsmen are assisted by employees of the Seimas Ombudsmen's Office in organising and performing activities of the national prevention of torture assigned to them. The employees of the Office regularly visit and inspect places of detention seeking to identify any indications of torture or other cruel, inhuman or degrading treatment or other human rights violations; they supervise the implementation of the Seimas Ombudsmen's recommendations in the area of national prevention of torture and perform other functions assigned.

Currently the Human Rights Division is composed of 4 employees (all of them are lawyers) who regularly visit and inspect places of detention and supervise the implementation of recommendations submitted after visits. Occasionally, the Ombudsmen also take part in preventive visits, and they are responsible for controlling the activities of the Human Rights Division.

Methodology for performance of the national prevention of torture

On 5 February 2014, the Head of the Seimas Ombudsmen's Office approved the Programme for Implementation of National Prevention of Torture establishing tasks and measures of national prevention of torture. The Programme for National Prevention of Torture contains analysis of the number of institutions in Lithuania falling into the category of places of detention defined in the Optional Protocol, models of activities and experience of national preventive mechanisms of other countries, the Optional Protocol Implementation Manual prepared by the Association for the Prevention of Torture, the Guidelines on National Preventive Mechanisms drawn up by the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of the Committee against Torture of the United Nations (the Subcommittee on Prevention) as well as standards, recommendations and reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (the Committee against Torture). The Programme also discusses types and methodology of inspection of places of detention.

In the course of performance of the national prevention of torture, questionnaire-based inspections, thematic inspections and in-depth inspections are carried out.

QUESTIONNAIRE-BASED INSPECTIONS

This type of inspection is based on completing questionnaires adapted to each institution; these questionnaires cover the most important issues related to ensuring security and suicide prevention, use of special, restrictive and disciplinary measures, material conditions of detention (housing), nutrition, health care, ensuring persons' independence and autonomy as well as provision of information and examination of complaints. These questionnaires are prepared taking into account the requirements of national and international legal acts as well as the standards of the Committee against Torture. Preparation for inspections included analysis of the requirements provided for in legal acts, the standards of the Committee against Torture and its reports following visits to Lithuania as well as collection of material on the institution to be inspected. Institutions were not notified in advance of questionnaire-based inspections. All inspections lasted no more than one day. No inspections lasted several days or were carried out during non-working days or public holidays.

In 2014 and in 2015 the majority of conducted inspections were questionnaire-based.

In 2014, thirty five questionnaire-based inspections were conducted. Out of that number, 10 questionnaire-based were carried out in social care institutions, 1 – in mental institution, 9 – in police custody facilities and premises of temporary detention, 5 – in imprisonment institutions, and 10 – in institutions of detention and accommodation of foreigners.

In 2015, thirty questionnaire-based inspections were conducted: 19 inspections in social care

institutions for adults, 5 – in police custody facilities and/or premises of temporary detention, and 6 – in frontier stations.

INDEPTH INSPECTIONS

An in depth-inspection is a comprehensive evaluation of human rights and freedoms.

In 2014 an in-depth inspection was carried out in the Foreigners' Registration Centre with the participation of several members of the Seimas Committee on Human Rights. The inspection lasted several months involving visits to the centre as well as gathering information from the institution and other sources. Following an inspection, a report was drawn up; the report contained detailed information on the situation of human rights and freedoms in the Centre, risk factors, problems identified and good practice.

THEMATIC INSPECTIONS

During thematic inspections, a concrete area (or areas) is focused on, for instance, provision of health care services, creation of general climate of security, prevention of smoking and alcohol consumption, imposition of penalties, issues of the staff, or concrete persons are focused on, for example, groups of vulnerable individuals (women, minors and persons with a physical disability), etc.

In 2014, thematic inspections were carried out in all six children's socialisation centres in Lithuania where the procedure for placement into pacifying rooms and conditions of keeping in these rooms were assessed.

Thematic inspections in 2015 encompassed ones conducted in imprisonment institutions (Lukiškės Remand Prison – Closed Prison, Panevėžys Correction House and Kaunas Remand Prison for Minors – Correction House), where ensuring of rights and freedoms of vulnerable inmate categories, such as women, minors and persons with a physical disability, was assessed. In addition, thematic inspections were carried out in child care homes (Antakalnis Child Social Care Home, Child Social Care Home "Gilė", public institution Children and Adolescents Social Centre and Mintis Child Social Care Home) where the issues assessed included ensuring a sufficient number of the staff, involvement of volunteers, treatment of children by the staff and protection against inappropriate behaviour, application of disciplinary measures, development of social skills, organization of leisure, familiarization of children with their rights and obligations, availability of information and others.

Thematic inspections are also performed in response to the information which appeared in the media. The Seimas Ombudsmen continuously monitor the information disseminated in the public space in relation to events in places of detention and decides to conduct monitoring of the human rights situation in an appropriate institution. In 2015, an inspection was carried out in the Foreigners' Registration Centre in response to the information which appeared in the media with regard to possible violations of the rights of persons detained there (regarding such issues as overcrowding of the Centre, residential premises infested with parasites, a possibility of cooking one's food and receiving nutrition according to religious and cultural convictions, organization of ad-

ditional activities and a lack of wheelchairs for persons with a disability of mobility).

STAGES OF INSPECTION

1. Preparation for the visit
2. Conducting the visit
3. Writing a report with findings and recommendations
4. Publishing the report on the Internet
5. Sending the report to the head of the monitored institution
6. Consultations regarding possible implementation measures of issued recommendations
7. Receiving feedbak from the place of detention
8. Considering whether to make a follow-up visit

Preparation for inspections included review of the requirements of legal acts, case law, and the standards of the Committee for the Prevention of Torture and its reports following visits to Lithuania collecting material about the institution to be inspected. Planned inspections were not notified in advance.

During the visit, officials carrying out an inspection communicated with heads of institutions, the staff of the administration and other staff as well as detainees and, if that was possible, with their relatives. Also, various premises (personal, common-use) were inspected, the installation of the premises was assessed, the infrastructure of the institution as well various registration logs and other documents were examined.

In the first year of work, following each inspection, a report was prepared with conclusions on noticed shortcomings and recommendations for eliminating them and it was submitted to the heads of institution, and, where necessary, to other responsible institutions.

However, it was noticed that many problems were systemic, therefore individual reports were replaced by common reports following inspections of several places of detention of the same type. Such reports assessed factual circumstances according to appropriate areas and described systemic human rights violations identified as well as the best practice observed in the institutions in order to improve the persons' living/detention conditions.

All reports on inspections in places of detention are published on the website of the Seimas Ombudsmen's Office.

It is noteworthy that according to Article 19^1 (6) of the Law on the Seimas Ombudsmen, competent institutions must examine proposals (recommendations) of the Seimas Ombudsmen, consult the Seimas Ombudsmen regarding possible measures for implementation of the proposals (recommendations) and notify the Seimas Ombudsmen of the results of implementation of their proposals (recommendations).

The institutions examined the conclusions set out in the reports and submitted plans for the implementation of the recommendations with specific timeframes for the implementation of particular recommendations. It should be noted that a part of the recommendations of the Seimas Ombudsmen were fully or partially implemented. Cooperation further continues regarding the recommendations which were not implemented.

We note with great pleasure the willingness to cooperate with the Seimas Ombudsmen's Office, to take into account the provided recommendations and make efforts to implement them demonstrated by the majority of institutions. Unfortunately, failure to implement the recommendations is often related to the lack of funding.

Seeking to ensure proper implementation of recommendations, the Seimas Ombudsmen carry out follow-up monitoring of the situation of human rights. Therefore, a lot of attention was paid to observing the implementation of the recommendations, namely the information on implemented recommendations or recommendation implementation plans submitted by institutions was carefully analysed and lacking information was requested. To the extent possible, follow-up visits were carried out.

FOLLOW-UP VISITS

The purpose of follow-up visits is to clarify the results of implementation of recommendations issued by the Seimas Ombudsmen since the control of recommendation implementation is a very important aspect of the national prevention of torture making it possible to establish whether the recommendations were implemented and what specific actions were undertaken by the institution to implement them.

In 2014 only one follow-up visit was carried out in a case where doubt arose as to whether the recommendations were indeed implemented. The institution was visited after the working hours and the information submitted by the institution was verified on site.

In 2015, more follow-up visits were conducted. The Seimas Ombudsmen made follow-up visits to one imprisonment institution, three care institutions for adults and two police custody facilities and premises of temporary detention.

INVOLVEMENT OF EXPERTS

While performing the national prevention of torture, it is crucial to involve experts, namely persons with special knowledge and competence who are capable of providing assessment of a situation based on their expert knowledge supported by practical skills.

In 2014, a preliminary roster of experts including representatives of various state institutions, research establishments and NGOs who expressed their consent to assist the Seimas Ombudsmen in the performance of the national prevention of torture, draft Rules of procedure for inclusion of experts in inspections of places of detention, and a draft model agreement on provision of expert services. This preparatory work was finished in 2015 adopting the *Rules of Procedure for Inclusion of Experts in Inspections of Places of Detention* (approved by 24 August 2015 Order No 1V-4 of the Head of the Seimas Ombudsmen's Office), *A Model Agreement on Provision of Fee-paying Expert Services with annexes: Certificate of Confidentiality (Annex 1) and Declaration of Objectiveness (Annex 2)* (approved by 24 August 2015 Order No 1V-42 of the Head of the Seimas Ombudsmen's Office), *A Roster of Experts for Inclusion in Inspections of Places of Detention* (approved by 3 December 2015 Order No 1V-65 of the Head of the Seimas Ombudsmen's Office) as well as the plan of the content of introductory training for experts and the memorandum of monitoring.

In 2015, external experts (psychologists) were involved twice during inspections of child care homes.

COOPERATION

While performing the function of the national prevention of torture, it is also important to ensure inter-institutional cooperation.

Thus, in 2014, a lot of attention was paid to meetings with experts in prevention of torture. Member of the Subcommittee on Prevention Mari Amos visited the Seimas Ombudsmen's Office twice and provided consultations to advisers of the Seimas Ombudsmen. During the first visit, the discussion with Mari Amos focused on issues of implementation of the Programme for National Prevention of Torture in Lithuania and sharing experience in monitoring of places of detention. The expert made recommendations on possible ways to improve methods of prevention and encouraged to draw up a 5-year plan of inspections in places of detention. During her second visit in Lithuania, the member of the Subcommittee on Prevention organised training at the Seimas Ombudsmen's Office and visited, together with employees of the Office, the Antaviliai care home for the elderly.

Cooperation possibilities in performing the national prevention of torture were discussed with representatives of the Psychological-Pedagogical Service of Vilnius City and Lithuania's representative on the Committee against Torture, psychiatrist Vytautas Raškauskas.

Seeking to develop cooperation and partnership with other institutions, the following meetings were organised: with the Ombudsperson for Children's Rights regarding the performance of the national prevention of torture in places of detention where children are kept, with the representative of the United Nations High Commissioner for Refugees in Lithuania regarding cooperation in eliminating human rights violations in the environment of asylum seekers and monitoring of the human rights situation in frontier stations, and with representatives of Lithuanian NGOs acting in the area of protection of human rights regarding cooperation and participation of experts in the implementation of the Programme for National Prevention of Torture.

In 2015 the Seimas Ombudsmen focused on meetings with heads of responsible authorities as well as places of detention and their associations organized in various counties of Lithuania. These meetings provided an opportunity to present the mandate of national prevention of torture as well as the most relevant problems identified in 2014–2015 and discuss solutions to such problems.

Most important systemic problems identified

SOCIAL CARE INSTITUTIONS

Problems indentified in Social Care Institutions

In 2014, the Seimas Ombudsmen assessed the human rights situation in ten institutions of social care (for disabled adults and the elderly). The following are the main problems and human rights violations identified:

1. Regarding ensuring safety of residents – In the majority of institutions inspected (in seven out of ten), defects of the emergency alert system were identified: in some institutions such system was not installed, while in others it did not function or was inefficient and did not perform its direct function of ensuring residents' safety. Another important aspect of residents' safety is the preparedness of residents and the staff of the institution for emergencies, for instance, a fire. In one of the institutions visited, a fire safety inspection had not been carried out, in another one, the staff and residents admitted that in case of fire they would not know what particular actions should be taken to ensure safe evacuation, in yet another one, stairs leading to the ground floor were especially steep, therefore, it was likely that in case of fire residents would not be able to evacuate in a timely and safe manner.

2. Regarding the living environment and conditions for the disabled – Not in all care institutions the environment of residential rooms was similar to that of home; the main entrance and other premises, including hygiene premises,

were inaccessible to the disabled; there were no appropriate conditions for moving independently, taking into account the age and the condition of health; it had not been ensured that all residents in their residential room have a possibility to observe the environment through the window, taking into consideration the hight of windows and the location of the bed. Cases have also been established where the required minimum living space per person (5 m2) was not ensured or residents were not sufficiently supplied with means of hygiene.

3. Regarding ensuring residents' privacy – In certain care institutions, residents did not have a possibility to lock their residential room from inside, it also happened that at night (and sometimes during the day) the staff locked residential rooms without the residents' consent; the staff did not knock on

the door before entering the rooms; at the time of washing and bathing the residents who are not able to do that themselves, screens were not used, privacy was not ensured during medical check-ups; there were no separate premises (a private space) for private meetings with family or friends, or where two residents could spend some time together; individuals did not always have a possibility to use all the cutlery.

4. Regarding individual care and encouragement of independence – Not in all care institutions individual social care plans were drawn up for residents following an assessment of their needs, or such plans were drawn up without the participation of residents, and the independence of residents was insufficiently encouraged: there were no appropriate conditions for residents to cook themselves (there was a lack of crockery and cutlery), there was no possibility to express their preferences with regard to foodstuffs and/or choice of dishes, or to independently develop skills by washing their clothes, etc.; individuals were not encouraged or taught to use a computer and the Internet; they were not encouraged to learn alternative communication skills such as Braille and/ or the sign language.

5. Regarding provided health care services – Not in all care institutions health care services were provided in compliance with the requirements of legal acts regulating provision of such services: there were no residents' signatures (regarding consent to or refusal of treatment prescribed to them) next to entries in medical histories of residents; residents were not notified of having an oncological disease; they were not offered to make use of state-funded preventive health care programmes; where physical restraint measures were applied to residents (medical belts, placement into the isolation room), decisions regarding their use were made not by a medical doctor, but by the administration of a care institution, and the application of such measures was not registered.

6. Regarding the adequate number and competence of the staff – Not in all care institutions the composition and number of the staff (24 hours a day) met the needs of residents; and not all the staff took part in training programmes on the rights of the disabled or the elderly. The majority of recommendations addressed to care institutions were related to the installation and proper functioning of the emergency alert system; also, several recommendations were provided regarding these issues: encouragement of independence of persons kept in institutions, appropriate organisation of leisure, ensuring privacy, accessibility of institutions' entrances and premises for the disabled, drawing up individual social care plans and participation of residents therein, appropriate provision of relevant information, and proper application of physical restraint measures; in addition, practically all institutions were advised to organise, as possible, training to the staff on protection of human rights and fundamental freedoms and the rights of the disabled.

In 2015, the Seimas Ombudsmen assessed the human rights situation in nineteen institutions of social care (for disabled adults and the elderly): The following are the main problems and human rights violations identified:

1. In 10 (ten) care institutions of Kaunas county, namely, public institution Rumšiškės Care Home for the Elderly "Auksinis Amžius",

public institution "Globasta", public institution Ežerėlis Nursing Home, Kaunas Panemunė Care Home for the Elderly, Kėdainiai Social Care Home, Jonava Care Home, Čekiškė Social Care Home, public institution Home for the Elderly "Užusaliai", public institution "Amžiaus Žiedas" and Vilijampolė Social Care Home (14 September 2015 Report No 2015/1-74);

2. In 9 (nine) care institutions of Panevėžys county, namely, public institution St Joseph's Care Home, the Centre of Services and Occupation for the Elderly and the Disabled of Pasvalys District, public institution Pasvalys Hospital, Jotainiai Social Care Home, public institution St Vincent de Paul's Care Home of Biržai parish, public institution Ona Milienė's Care Home for the Elderly, Kupiškis Social Services Centre, Legailiai Social Care Home, and public institution "Vilties Namai".

Inspections were also conducted in **four** child care institutions of Vilnius county, namely, Antakalnis Child Social Care Home, Child Social Care Home "Gilė", public institution Children and Adolescents Social Centre, and Mintis Child Social Care Home (29 February 2016 Report No 2015/1-137).

Follow-up inspections in Social Care Institutions

Follow-up inspections were carried out in **three** social care institutions for adults, namely, Paberžė Care Home (13 May 2015 Report No 2015/1-47), the Home for the Elderly of public institution "Sevilis" (13 May 2015 Report No 2015/1-48), and the Care Division of Eišiškės Personal Health Care Centre (13 May 2015 Report No 2015/1-49).

The following are the main problems and human rights violations identified:

1. Regarding ensuring safety of residents – Not all institutions were able to provide appropriate additional care and services to persons (aggressive residents) which needed such services; in certain care institutions, defects of the emergency alert system were identified: in some institutions, such system was not installed (including personal hygiene premises), while in others it was not accessible to all residents or was not always within reach of a hand, or it did not function or was inefficient, and sometimes the staff did not respond to the emergency signal; assessing the safety of residents in case of a fire (fire safety) or in case of other emergencies, it was observed that in some institutions stairs leading to the ground floor were steep; in certain institutions, evacuation stairs were not installed properly; in some institutions, accidents were not registered in a special log or were registered inappropriately.

2. Regarding ensuring residents' privacy – In certain care institutions, residents did not have a possibility to lock their residential room from inside (considering the level of their independence), it also happened that the staff locked residential rooms without the residents' consent; often, the staff did not knock on the door before entering the rooms (or they did not always knock); privacy was not ensured in personal hygiene premises; in one institution, video surveillance cameras were installed in residents' rooms; sometimes, 5–6 residents shared the same room; in one institution, residents lived in a room which led yet to another room; privacy

was violated when a person with mental disorders disturbed other residents; at the time of washing and bathing the residents who were not able to do that themselves, or changing their diapers, screens were not used; privacy was not ensured during medical check-ups.

3. Regarding shortcomings related to adaptation of premises to disabled persons and mobility on the territory of the institution – In some institutions, the main entrance and other premises, including hygiene premises, were inaccessible to the disabled; the territory was not adapted to the residents' needs, there were no appropriate conditions for moving independently, taking into account the age and the condition of health; sometimes, residents did not have a possibility to use a lift when they needed it; it was not ensured that all residents with a mobility disability in their residential room had a possibility to observe the environment through the window, taking into consideration the height of windows and the location of the bed; not all institutions had a possibility to take outside persons with a severe mobility disability (who were always lying in bed).

4. Regarding individual care and encouragement of independence – Not in all care institutions individual social care plans were drawn up for residents following an assessment of their needs, or such plans were drawn up without the participation of residents, or the plans were not reviewed according to the timeframe provided for in legal acts, or social work was not always recorded in detail; cases were also identified when the independence of residents was insufficiently encouraged: in one institution, autonomy promotion programmes were not conducted at all, which was explained by a severe health condition of residents; there were no appropriate conditions for residents to cook themselves (a kitchen was not appropriately installed); residents were not encouraged to use all cutlery when eating, or to independently develop skills by washing their clothes and taking care of their personal hygiene, especially oral hygiene; individuals were not encouraged or taught to use a computer and the Internet.

5. Regarding application of restrictive measures – Sometimes, restrictive measures were applied without a clearly-defined procedure and a medical doctor's permission, or continual surveillance of a person subject to such a measure was not ensured, it was also identified that cases of application of such measures were not always registered or were registered, but not in a special log.

6. Regarding provided health care services – Not in all care institutions health care services were provided in compliance with the requirements of legal acts regulating provision of such services: there were no residents' signatures (regarding consent to or refusal of treatment prescribed to them) next to entries in medical histories of residents; not in all institutions the right of residents to refuse treatment was ensured; where physical restraint measures were applied to residents (medical belts, placement into the isolation room), decisions regarding their use were made not by a medical doctor, but by the administration of a care institution; in some institutions, medicinal products were not suitable for use (they were past the expiry date); besides, residents often purchased various medicinal products from their own funds; in certain institutions,

residents did not have a possibility to receive services of a psychologist; some institutions, possibly, inappropriately conducted harmful habits' prevention programmes.

7. Regarding the adequate number and competence of the staff – Not in all care institutions the composition and number of the staff (24 hours a day) met the needs of residents, in addition, when only the minimum number of the staff was ensured, this number was not sufficient; it was also established that not all the staff took part in training programmes on the rights of the disabled or the elderly; the staff was not sufficiently informed about mental health care, management of aggressive behaviour, psychology of conflicts and prevention of violence, and they did not always improve their skills in the areas of rehabilitation services, patients' rights, mental health law and social care law; in several institutions, the staff used stigmatizing epithets and treated residents in an unethical and disrespectful manner, or performed their obligations inappropriately; in the majority of institutions, internal work organization was not always based on a just work pay and appropriate workload.

8. Regarding ensuring the minimum living space requirements, and ventilation, cleanness and lighting of premises – In one institution, the requirement of the minimum living space was violated when a premise was shared by more people than the envisaged number of places; sometimes, a room was shared by more than 4 residents; not all institutions ensured cleanness and order; not in all institutions, residential premises were ventilated, there was a lack of ventilation equipment; in residential rooms of several institutions, there was too little daylight and/or artificial light.

9. Regarding installation of premises, provision of inventory to residents and personal hygiene – During inspections it was established that the environment of residential rooms was not always sufficiently similar to home environment; in some institutions, there was a lack of furniture (tables, cupboards), not all inventory was in good order (broken doors, furniture with ragged upholstery, cabinets without handles, a cupboard with a broken door lock, a light switch in a toilet was not working, a television set was not working because of a lack of a plug-in); not in all institutions, residents had appropriate conditions for eating; not in all institutions, the number of showers and bathroom premises as provided for in legal acts met the residents' needs; not everywhere, residents had a possibility to keep their personal belongings safely in locked cupboards or cabinets; in the majority of institutions, mattresses given to residents were often worn-out, dirty or torn, and they were not disinfected before passing them over for use to other residents; in almost all institutions, residents' underwear was changed once a week; there were doubts on numerous occasions whether residents who were not able to take care of themselves were washed every day and whether sheets and clothes were changed according to the need, but at least once a week; in some institutions, clothes and/or shoes worn by residents were dirty and/or ragged; in one institution it was established that the institution did not wash personal clothes of residents; sometimes personal hygiene means were over in sanitary units; residents often used the same personal hygiene means; the institution did not supply all necessary hygiene means to residents

(quite often, residents bought means of oral hygiene from their own funds).

10. Regarding availability of information and satisfaction of residents' wishes – In all institutions it was established that residents were only formally familiarized with internal regulations and that their rights and obligations were not explained to them in a language they understood; not all institutions had information boards with relevant information; in several institutions it was established that residents did not know how to behave if they experienced inappropriate treatment from the staff or other residents; newly arrived residents were not always asked about a person they wanted to share a room with; a case was established that an institution did not consider moving a person out of a room when persons sharing the room were always arguing; it was also established that residents were often afraid and did not have enough courage to submit requests to the administration; there were cases when the staff did not take residents' requests into consideration (regarding non-functioning television or radio sets; domestic help to a person with a physical disability; controlling noisy neighbours); in some institutions, the staff did not provide answers to residents' inquiries; it was also established that in one institution the staff did not buy various items for residents and did not even offer such a service; in other institutions, following a purchase of items which residents asked for, copies of receipts were not kept, which made it difficult to address related problems (regarding purchase of inappropriate items, or possible misappropriation of money by the staff while buying items for residents); not in all institutions residents were asked about desirable nutrition, and sometimes residents' wishes regarding a menu were not taken into account (to put less salt into food); not in all institutions there was a possibility for residents to familiarize themselves daily with a menu in the format understandable to them; in one institution, the same food was provided according to the same menu every two weeks.

11. Regarding other observed violations – During inspections it was also established that in some institutions menus were drawn up by a member of the staff who did not have special knowledge or appropriate education necessary for drawing up menus; in one care institution it was established that a part of residents was served food in disposable plastic crockery; in another institution, residents who had been ill with tuberculosis in the past were accommodated and fed separately from others; not in all institutions residents' clothes were individualized, residents were clothed in common-use clothes; in certain institutions, residents lacked versatile leisure activities or such activities were not organized at all; not everywhere, residents had a possibility to use alternative communication means in cases a person did not have or had lost the ability to speak or other communication abilities due to the health condition; not all institutions provided a possibility for an unmarried couple to live together, sexual education was not conducted either and/or nothing was done to ensure provision of contraceptives to residents.

Recommendations following inpsections in Child Care Institutions

Following inspections in ten social care institutions for adults of Kaunas county, 41 recommendations were issued: to the Ministry of Social

Security and Labour of the Republic of Lithuania (8), the Ministry of Health (1), the State Food and Veterinary Service (1), the Fire and Rescue Department and the Department of Supervision of Social Services (31).

While providing information on the implementation of 31 (thirty-one) recommendations addressing the shortcomings specified above, the Department of Supervision of Social Services indicated that all the institutions listed in the Report would be included into a list of more risky institutions and a plan of care institutions to be assessed according to the relevance of information provided in the Report and, if need be, appropriate measures would be taken.

The Ministry of Health also agreed with a recommendation provided by the Seimas Ombudsman regarding improvement of legal regulation, drew up draft amendments to legal acts and submitted them for approval to stakeholder institutions.

Yet another recommendation related to amendment of legal acts by providing for an obligation for social care institutions for adults to coordinate menus with territorial divisions of the State Food and Veterinary Service also received support from the director of the Service, however, he proposed to include such a requirement not into the Law on Food of the Republic of Lithuania but into another legal act.

The Ministry of Social Security and Labour agreed in principle regarding 4 (four) recommendations indicating that institutions were encouraged to improve the competence of the staff in various ways, besides, the skills of a staff member of a care institution had to be improved taking into account his/her practical activities; if there were residents wishing to leave a care institution and live independently in the community, care institutions were obligated to take steps and help such a person as well as make sure that he/she would be ensured appropriate living conditions and provided necessary services in the community, in addition, the deinstitutionalization process of care institutions which was underway currently would help to better assess how many and what services were accessible to persons willing to leave a care institution and live independently in the community as well as provide them; when conducting inspections, the Department of Supervision of Social Services always evaluated whether the environment of an institution was adapted to persons according to their needs and whether legal acts ensured transfer of orderly and clean mattresses and sheets to residents, however, the Ministry also noted that it had addressed social care institutions and would consider a necessity of improvement of legal acts.

However, several recommendations (4 out of 8) remained unimplemented. The Ministry of Social Security and Labour indicated that there was no necessity to improve legal regulation regarding the establishment of a higher minimum number of the staff, drawing up of guidelines for recording (description) of social work, the establishment of rights to living in a couple, sexual education and availability of contraceptives, or supplementation of the licensing procedure with the minimum fire safety requirements. According to the Ministry, current legal regulation is sufficient and ensures the provision of quality services of long-term social care.

It is noteworthy that with regard to recommendations issued by the Seimas Ombudsmen, with which the institutions did not agree, further

cooperation will be pursued and solutions to problems will be sought in order to improve the human rights situation in care institutions.

So far no information has been received on the implementation of recommendations provided following inspections in social care institutions for adults of Panevėžys County.

During 2015, follow-up inspections were also conducted in three social care institutions for adults, namely, Paberžė Care Home, the Care Division of Eišiškės Personal Health Care Centre and the Home for the Elderly of public institution "Sevilis", in order to assess whether the recommendations provided during prior inspections were implemented (28). Follow-up inspections revealed that 25 recommendations had been implemented (or partially implemented), while 3 recommendations remained unimplemented, therefore, the institutions were again advised to take measures to ensure appropriate implementation of all the recommendations, besides, 4 recommendations were issued regarding additional shortcomings identified during the follow-up visits (23 in total).

According to the data provided by the institutions, they managed to implement almost all the recommendations (22): vacant staffing positions were filled in, emergency alert buttons were installed in residents' rooms, old emergency alert buttons were replaced by new ones, reminders were posted on the walls with information on the staff which can help on various issues, the "post" of secret complaints, requests and notifications was prepared, and on information boards residents can find information on which institutions to address outside the care home. In all hygiene premises, additional cabinets with hygiene items accessible to residents were placed; in order to ensure residents' privacy door signs "free" and "occupied" were hung on hygiene premises' doors; and the staff were once again reminded about their obligation to knock before entering residents' rooms and the prohibition to lock residents' rooms. A form of a resident's consent to the treatment prescribed was approved and is signed in each specific case. Residents' files were reviewed and all shortcomings related to individual social care plans were eliminated (the plans were reviewed and approved and signed by residents). In a social workers' office, residents may familiarize themselves with the United Nations Convention on the Rights of Persons with Disabilities or read the most recent articles on social skills, the society's attitude towards the disabled and the social environment. Residents started using a kitchen installed in an institution more often. Due to a lack of funding, a recommendation regarding the installation of a wheelchair ramp to the main entrance of an institution and a lift for the disabled remained unimplemented.

CHILD CARE INSTITUTIONS

Problems identified in Child Care Institutions

The following are the main problems and human rights violations identified in 2015:

1. Regarding the composition and number of the staff – If a member of the staff falls ill, goes on vacation, etc., the number of the staff is not sufficient; institutions need a psychologist on the staff, however, they do not have one; the absolute majority of the staff doing social and teaching work are women; mixed

composition of the staff in terms of gender helps to prevent inappropriate behaviour.

2. Regarding working hours and work pay – The workload is high, while salaries of social workers are not sufficient; the turnover of the staff is high, which does not encourage the formation of a close positive relationship between children and the staff.

3. Regarding upgrading of qualifications – Qualifications upgrading seminars for social workers and their assistants are very expensive, institutions have no funding for such training courses, while the staff cannot always afford to pay for them themselves.

4. Regarding the activities of volunteers – The procedure for voluntary activities does not operate appropriately, because the requirements for volunteers are not provided for

5. Regarding the general climate of safety – Problems arise concerning children with behavioural and emotional disorders, because the staff are not able to provide specialized services to such children; the children are not supervised by a psychiatrist; and the Child Development Centre no longer provides recommendations on how to work with such children.

6. Regarding the treatment of children by the staff and the protection against inappropriate treatment – Communication of the staff with children is inappropriate, the staff speak too loudly or even shout angrily.

7. Regarding applied disciplinary measures and the control of children's behaviour – Children who behave inappropriately are subject to disciplinary measures, including the prohibition to go outside of the territory of a care home or go home on weekends or bank holidays, restrictions on entertainment activities or participation in trips or camps, the prohibition to take part in celebrations held in an institution, isolation from other children, restoration (repair) of damaged objects, reading a book on a certain subject (about the love for younger ones or good behaviour); children who behave inappropriately also have to draw up an explanation about their behaviour and read it out loud to all the children; quite often, children are disciplined by reducing the amount of pocket money or its withdrawal; when left in charge of the younger ones, older children would discipline them for inappropriate behaviour.

8. Regarding appropriate preparation of children for independent life (development of responsibility) – There are no possibilities for children to have a pet (to take care of it), older children are not sufficiently encouraged to cook independently.

9. Regarding prevention of smoking and alcohol consumption – Quite a lot of children smoke, and sometimes they return to an institution intoxicated with alcohol; educators often do not consider such behaviour of children to constitute a violation of the internal rules.

10. Regarding the procedure for payment of pocket money – Children of similar age receive a different amount of pocket money in different institutions; the procedure for payment of pocket money may be abused by an institution by withdrawing pocket money

from children; children are required to specify how they are planning to use the money and to report on the money spent.

11. Regarding ensuring personal hygiene means – Centralized acquisition of personal hygiene means does not ensure a possibility for children to participate in their acquisition and express their opinion.

12. Regarding creation of conditions for doing homework – The number of desks and chairs in the rooms did not correspond to the number of children living in the premises.

13. Regarding children's leisure – Due to the attitude of the administration towards differentiation of leisure clubs or groups according to children's gender, conditions for club/group attendance are different; children are not happy with the quality of clubs/groups they attend, while their complaints are not taken into account, and their wishes concerning the clubs/groups they would like to attend are not considered either.

14. Regarding familiarization of children with their rights and obligations, availability of information and examination of inquiries – Due to the fact that anonymity might not be ensured, some children avoid approaching either their educators, or the administration.

15. Regarding the "label" of a child from a care home – Children from an institution are often "labelled" negatively. Children face a stigmatizing attitude both in educational and personal health care institutions, and in the local community.

Recommendations following inspections in Children's Socialisations Centres

24 recommendations were provided to responsible institutions in relation to the shortcomings indicated above. Information on the implementation of the provided recommendations has not been received yet.

CHILDREN'S SOCIALISATION CENTRES

Problems identified in Children's Socialisation Centres

In 2014, the Seimas Ombudsmen assessed the human rights situation in six children's socialisation centres (Vėliučionys Children's Socialisation Centre; Vilnius Children's Socialisation Centre; Kaunas Children's Socialisation Centre Saulutė; Kaunas Children's Socialisation Centre; Gruzdžiai Children's Socialisation Centre; Children's Socialisation Centre Širvėna).

The following are the main problems and human rights violations identified:

1. Regarding lawfulness of the use of pacifying rooms – In certain children's socialisation centres, pacifying rooms were still used, thereby posing a possible risk of violation of children's rights. Such violations may result from failure to comply with the procedure provided for in legal acts and the standards of the Committee against Torture: in certain children's socialisation centres, the scope of circumstances under which a child may be placed in a pacifying room was unreasonably extended, and a child was placed into the pacifying room without first trying to calm him/ her down by other

means; no measures were taken to ensure that the child is kept in the pacifying room for as short a time as possible; following the child's placement into the pacifying room, the problem of the child's behaviour which resulted in the placement to the room was not addressed.

2. Regarding safe, secure and appropriate conditions in pacifying rooms – In one of the centres, the number of pacifying rooms was insufficient; therefore, more than one child at a time was placed therein; in another centre, pacifying rooms did not meet the applicable installation requirements; proper surveillance of the child placed into the pacifying room was not ensured; in certain cases, in order to place the child into the pacifying room, special measures were applied which are allowed against minors only in exceptional cases – when they resist in a manner endangering human life or health.

3. Regarding registration of information, notification and complaining against placement in pacifying rooms – In many children's socialisation centres, conclusion was drawn that information on placing and holding children in pacifying rooms was not properly registered; in one of the centres, there were no possibilities for the child to file a complaint against his/her placement into the pacifying room. Inspections of children's socialisation centres focused only on the assessment of the conditions and situation of the placement of children residing in the centres into pacifying rooms. Following the inspection, one joint report with summarised conclusions was drawn up. It was recommended that the Minister of Education and Science consider a possibility, in accordance with the good practice applied by the two socialisation centres indicated by the Seimas Ombudsmen, to abandon the use of pacifying rooms in the remaining socialisation centres; should a decision be made to install and use pacifying rooms, it should be ensured that children's rights are not violated due to installation and use of these rooms; undertake appropriate actions to prevent unlawful use of special measures against children in one of the inspected socialisation centres.

THE MENTAL INSTITUTION

In 2014, the human rights situation was assessed in one mental institution (Šiauliai Psychiatric Hospital). The following are the main problems and human rights violations identified:

1. Regarding safe, secure and appropriate conditions – A part of premises was not under surveillance by video cameras; therefore, secure environment for patients and the staff was not adequately ensured. Besides, the living space in a ward per patient (bed) (7 m2), as required by legal acts, was not ensured. In some wards, there were more than 4 beds, and there were no single-occupancy wards. There were also doubts as to whether it was reasonable to restrict a possibility to take a walk outside and as to the need for smoking premises.

2. Regarding ensuring the right to privacy – The patients had no possibility to lock hygiene premises from the inside; there were no separate premises for patients to have meetings with family or friends without the presence of strangers; patients were not guaranteed

nutrition according to religious, cultural or other convictions; patients did not have a possibility to express their preferences with regard to the choice of food.

3. Regarding ensuring the right to receive information – There were doubts as to whether patients were always appropriately informed about the prescribed treatment, its duration and efficiency, medication they are taking, the possibility of alternatives, etc.; the patients' right to have access to medical documents and receive extracts thereof in accordance with the effective legislation was not ensured; information on sexual and reproductive health was not provided. If need be, interpretation services would not be ensured to patients.

4. Regarding the analysis of patients' written submissions – It was established that the institution does not perform the analysis of issues raised in patients' written submissions.

The mental institution was given recommendations regarding appropriate provision of information to patients, ensuring possibilities to exercise the right to privacy, ensuring the minimum living space per patient, proper registration of cases of physical restraint of patients and the analysis of patients' written complaints, requests, etc.

POLICE CUSTODY FACILITIES

In the course of assessment of the human rights situation in police custody facilities and premises of temporary detention in police stations in 2014, inspections were conducted in custody facilities and premises of temporary detention of

four police stations as well as premises of temporary detention of **one** police station (custody facilities and premises of temporary detention of Šalčininkai Police Station of the Police Headquarters of Vilnius County; custody facilities and premises of temporary detention of the Police Headquarters of Panevėžys County; premises of temporary detention of Panevėžys Police Station; custody facilities and premises of temporary detention of the Police Headquarters of Alytus County; custody facilities and premises of temporary detention of Elektrėnai Police Station of the Police Headquarters of Vilnius County).

The following are the main problems and human rights violations identified:

1. Regarding violations of hygiene norms and installation of premises – Most common finding was that the detention conditions failed to comply with the hygiene norms, besides, a number of cells and premises of temporary

detention did not meet the requirements for the installation of such premises: cells were often insufficiently clean, the obligation to provide detained persons only with disinfected (cleaned) soft inventory (a mattress, a pillow, a blanket) was not always complied with, privacy was seldom ensured in sanitary units of cells, and the sanitary equipment was technically faulty; conditions were not provided for drying the laundry; interrogation rooms and residential cells were often not under surveillance by video cameras, there were also cases where the minimum living space per person in custody (5 m2) was not ensured. It was also noticed that main entrances to police stations and other premises were not adapted for the disabled.

2. Regarding accessibility of health care – Medical posts were installed not in all custody facilities, and some medical posts operated in conflict with the requirements of legal acts regulating the activities of such services (for instance, they did not have a licence or a permit-hygiene passport); detainees did not always have a possibility to see a psychologist and/or a psychotherapist; medical documents were filled in inappropriately; in certain cases the quality of food supplied to detainees was not checked. There were also cases established where detained persons were not supervised and checked by a health care specialist with only emergency medical care accessible to them; the condition of health of detainees on a hunger strike was not monitored. 3. Regarding appropriate access to information – There were cases where persons placed into custody were inappropriately informed of their rights and the internal regulations of police custody facility.
3. Regarding access to additional out-of-cell activities – In certain custody facilities, detainees had completely no access to sports, cultural and leisure activities.

Custody facilities were mostly recommended to ensure the minimum living space per person (5 m^2), adaptat premises and entrances for the disabled, ensure that the cells are kept clean, provide possibilities to detainees to dry the laundry, ensure privacy by correspondingly screening off sanitary units; provide detained persons with adequate information about their rights and obligations, and provide proper access to information relevant to detainees.

In 2015, inspections were conducted in **five** police stations: custody facilities and premises of temporary detention of the Police Headquarters of Utena County; custody facilities and premises of temporary detention of Varėna District Police Station of the Police Headquarters of Alytus County; custody facilities and premises of temporary detention of Švenčionys District Police Station and premises of temporary detention of Trakai District Police Station of the Police Headquarters of Vilnius County; and custody facilities and premises of temporary detention of Kėdainiai District Police Station of the Police Headquarters of Kaunas County (21 May 2015 Report No 2015/1-22).

FOLLOW-UP INSPECTIONS IN POLICE CUSTODY FACILITIES

In addition, **follow-up inspections were conducted in two** police custody facilities and premises of temporary detention in police stations, which had been inspected in August–September

2014: custody facilities and premises of temporary detention of the Police Headquarters of Alytus County (9 June 2015 Report No 2015/1-54) and custody facilities and premises of temporary detention of Elektrėnai Police Station of the Police Headquarters of Vilnius County (5 June 2015 Report No 2015/1-61).

The following are the main problems and human rights violations identified:

1. Regarding an insufficient number and competence of officers as well as their working conditions – Not all the positions of officers are filled in, working conditions could be assessed only as satisfactory, not everywhere officers have a possibility to upgrade their qualifications often enough and in some institutions officers demonstrated inappropriate attitude towards detained persons.

2. Regarding detention conditions and supply – Persons are still kept in premises the area of which is less than 2 m2 (even if for very short periods of time), not everywhere the minimum living space provided for one person held in custody (5 m2) is ensured, not everywhere premises are clean enough and appropriate ventilation, natural lighting and dignified personal hygiene conditions are ensured; in all police stations and police headquarters, the environment of courtyards used for taking a walk should be improved; due to the condition of meeting rooms, persons' right to see people is not adequately ensured; not always the timeframe of detention of persons in premises of temporary detention provided for in legal acts is observed; detained persons are not always supplied with appropriate and sufficient hard and soft inventory provided for in legal acts; disabled persons do not always have access to premises without additional difficulties; there no possibilities to wash one's clothes and sheets, and persons who do not have appropriate clothing are not supplied with clean clothes according to the season; detainees and convicts are transported from institutions of imprisonment to police custody facilities for interrogation and other pre-trial investigation actions even though the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment criticized this practice several times and proposed to stop it.

3. Regarding ensuring of safety – Rubber bats carried by officers are quite noticeable even though such practice is not necessary for ensuring safety and does not promote good relations between the staff and detainees; when the liberty of persons is restricted, not all characteristics determining their assignment to a risk group or a group of vulnerable persons and special needs are taken into consideration, not all police stations and police headquarters follow the requirements of isolation of persons; not everywhere interrogation rooms are appropriately installed and video recordings of interrogations are made.

4. Regarding organization of nutrition and health care – The quality of food supplied to custody facilities is not always checked; there were doubts as to whether the food supplied was of adequate nutritional value and whether menus were drawn up taking into account physiological nutrition standards of different groups of persons; in one custody facility, detainees are not allowed to

use their own metal spoons; persons brought to custody facilities do not always receive a check-up by a health care specialist within 24 hours, sometimes because there is no medical office in the facilities, while in one custody facility the medical office did not have a permission-hygiene passport and medicinal products kept in the office were unsuitable for use; in one custody facility detainees did not have a possibility to see a psychologist; there were cases when medical documents were not filled in appropriately.

5. Regarding shortcomings of the Electronic Register – During inspections, it was established that as from 9 February 2015 data on persons kept in premises of temporary detention or custody facilities were uploaded into the Electronic Register, however, the new Register did not contain all data on the duration of the persons' presence in the police station/headquarters and premises of temporary detention, or on the fact whether a person was placed into premises of temporary detention at all; when an extract was printed out, it lacked more than a half of the data on the time of release of persons from the police station/headquarters and those data did not coincide with the data in the Electronic Register; in the Register, there are no possibilities to receive information on the performance of a certain specific action (for instance, taking a detainee out of a cell), the format of a log is not appropriate and the log does not record data on a person's refusal, for example, to go for a walk outside.

6. Regarding the persons' (including citizens of foreign countries) right to receive information – Detainees are only formally familiarized with the internal regulations of custody facilities, in some custody facilities (cells) the internal regulations are not posted on the wall, citizens of foreign states are not familiarized with their rights, obligations and prohibitions in a language they understand (the internal regulations of police custody facilities are available only in Lithuanian).

Recommendations following inspections in Police Custody Facilities

Following inspections in five police stations/headquarters, 20 recommendations were provided to the Police Commissioner General of the Republic of Lithuania. The majority of them (12) were implemented or partially implemented. In addition, all territorial police stations and their divisions were familiarized with a report on inspections by drawing their attention to shortcomings identified in the report and instructing them to take measures to ensure that the indicated shortcomings were avoided when organizing the work in police custody facilities and premises of temporary detention.

Taking into account the provided recommendations, A plan of measures for improvement of conditions of detainees in police custody facilities and premises of temporary detention was approved whereby the following was provided for: to close down custody facilities of Varėna Police Station (by 1 April 2016); to review the timeframe of keeping detainees in premises of temporary detention; to renew soft inventory used in police custody facilities as well as sheets and towels; to assess possibilities of reconstruction of premises of sanitary units, calculate the required funding and provide for that funding according to financial possibilities; in

courtyards of custody facilities intended for taking a walk, to install places for detainees to rest; and to acquire clothing to be handed out to detainees who are dressed not according to the season (to clothe them temporarily). Territorial police stations were instructed to keep rubber bats in the security territory of the internal post and, if need be, to ensure their use; and agreements were concluded with translation agencies in order to guarantee the right of foreign citizens to receive information. Shortcomings identified during inspections were also taken into consideration when improving the module of the Electronic Register.

The Police Headquarters of Vilnius County informed that in Trakai District Police Station, following the receipt of funding, vacant positions of officers would be filled in. In accordance with the amendments of Article 2 of the Law on Arrest Enforcement drafted by the Ministry of Justice of the Republic of Lithuania, the term of transfer of detainees (during a pre-trial investigation) from a remand prison to custody facilities of a territorial police station was reduced to 5 days and nights (in order to conduct procedural actions if the performance of procedural actions cannot be ensured while detainees are in a remand prison or due to the participation of detainees in the examination of cases in court; the amendments will take effect from 1 April 2016). The Police Department also approached public health centres and the State Food and Veterinary Service asking to assess possible shortcomings indicated in the report. To address the problem of sobering of detainees, the Ministry of Health set up an interdepartmental working group which also included representatives of the Police Department.

Not all the recommendations issued by the Seimas Ombudsmen were implemented. Regarding ensuring of the minimum living space for one detainee in police custody facilities, the Police Department informed that instead of following Item 80 of the Regulations of Activities of Custody Facilities of Territorial Police Stations approved by 29 May 2007 Order No 5-V-356 of the Police Commissioner General of the Republic of Lithuania providing for the living space of at least 5 m2, they followed the 18 January 2013 judgement of the Administrative Court of Lithuania in administrative case No A858-105/2013 which explained that one person must be ensured a space which was not less than 3.6 m2. Provision for mandatory filming of interrogation, according to the Department, will not protect a suspect against violation of his/her interests or rights, because an investigator's meetings with a suspect are also possible prior to interrogation, besides, provision for mandatory filming of interrogation could violate the rights of persons who do not wish to be filmed during interrogation.

The situation with the recommendations provided by the Seimas Ombudsmen, with which the Police Department did not agree, is further clarified and solutions to problems are sought in order to improve protection of human rights in police stations/headquarters.

During 2015, follow-up inspections were also conducted in two police institutions – the Police Headquarters of Alytus County and Elektrėnai Police Station – in order to assess the implementation of recommendations (18) provided during inspections in 2014. Follow-up visits revealed that 8 recommendations had been implemented, while others had not been implemented or had been partially implemented (10), therefore, it was recommended to take measures to ensure the implementation of all the recommendations. The management of the police headquarters and the

police station informed that 5 recommendations had been implemented: a permission-hygiene passport was received; beds were removed from cells to ensure that the area of the cell complied with the requirements; cooperation with primary health care institutions regarding the provision of a psychologist's services was ongoing; and drying rooms were installed for drying the laundry of detainees. While still waiting for appropriate funding from the Police Department, the following recommendations remained unimplemented: regarding installation of video surveillance cameras in interrogation premises, adaptation of the entrance to the disabled, repairs of premises of sanitary units, and reconstruction of courtyards used for taking a walk.

IMPRISONMENT INSTITUTIONS

In 2014, the Seimas Ombudsmen assessed the human rights situation in four imprisonment institutions (two correction facilities and two remand prisons) (Marijampolė Correction House; Vilnius Correction House (Rasų Street Sector and Sniego Street Sector); Kaunas Remand Prison).

The following are the main problems and human rights violations identified:

1. Regarding vacant staff positions – In some of imprisonment institutions, there were vacant staff positions.

2. Regarding officers' behaviour in cases of self-harm by inmates – In one imprisonment institution, there were cases recorded when persons were kept handcuffed for a particularly long period of time because they were harming themselves due to unwilingness to be transported with convoy.

3. Regarding assessment of proportionality of the use of special measures – No assessment of proportionality of the use of special measures was provided in the conclusions regarding disciplinary investigations into the use of special measures.

4. Regarding performance of searches – In certain imprisonment institutions, neither the supervising inmate of the cell nor any other person detained in the cell were present during the performance of searches of persons and premises; searches were filmed inappropriately or were not filmed at all. Regarding detention conditions – A part of premises of imprisonment institutions was inaccessible for the disabled; the minimum living space per person (5 m^2) was often not ensured; there was a lack of both natural and artificial lighting; there was also a lack of furniture and hard inventory; adequate cleanliness of sanitary units was not ensured; in some cases smoking inmates were

kept together with the nonsmoking ones; not all outside yards were clean.

5. Regarding provided health care services– Persons who were imposed with a penalty – solitary confinement – were not regularly visited by a health care specialist; health care services were possibly provided without compliance with the requirements of legal acts regulating the provision of such services; furthermore, there were doubts as to whether the convicted persons were properly informed of the treatment prescribed to them and agreed to receive it.

6. Regarding nutrition – Dietary or special nutrition for medical indications was not always ensured.

7. Regarding provision of toiletry items – In one imprisonment institution, toiletry items were kept in inappropriate conditions.

8. Regarding out-of-cell activities – The range of outof-cell activities that detained persons could engage in was insufficient.

9. Regarding dissemination of information – Citizens of foreign countries were not always informed of their rights, obligations and prohibitions applied in the language they understand.

A FOLLOW-UP INSPECTION

A follow-up inspection was conducted in one imprisonment institution – Marijampolė Correction Home. The following are the main problems and human rights violations identified:

1. Regarding the number and composition of the staff and improvement of qualifications – Detainees are not always provided continuous services of a psychologist, social worker and other staff of the social rehabilitation division; in upgrading of qualifications, the subjects related to questions relevant to minors are not sufficiently covered, while specialized subjects on women inmate issues are nonexistent.

2. Regarding the use of special measures, searches and imposition of penalties – When applying the measure of tying, there is a possibility of abuse and inappropriate treatment by officers; searches are not filmed or only several of them are filmed in a year; inmates kept in a disciplinary group are not ensured a possibility to contact officers except with major efforts; penalty isolation cells are not installed appropriately; convicts serving a penalty in a penalty isolation cell are not visited by a medical specialist daily; women inmates kept in a disciplinary group may

not use their courtyard for taking a walk; a courtyard intended for taking a walk which is assigned to a penalty isolation cell is small and dark.

3. Regarding the environment and privacy – Institutions' entrances to premises and premises themselves are not fully adapted to the disabled; rubber bats openly carried by security officers do not create a psychological climate suitable for the staff and inmates.

4. Regarding detention and hygiene conditions – The minimum living space per person provided for in legal acts is not ensured; newly arrived inmates are temporarily kept in cells smaller than 2 m^2; conditions in quarantine premises are to be considered as below human dignity; there is mould on the walls and the ceiling; there is no appropriate lighting; cleanness is not ensured in sanitary units, privacy is not ensured when using a bidet; mechanisms of sanitary units did not function or were damaged; conditions are not provided for inmates to wash themselves after work.

5. Regarding material and domestic supplies – Worn-out, damaged furniture; sufficient amount of hard inventory is not ensured; conditions are not provided to keep clothes and other personal items; worn-out floors; poor condition of soft inventory: stained, visually dirty, torn mattresses and blankets; when a person is moved from a remand prison to a correction house, he/she is not given the necessary personal hygiene means.

6. Regarding organization of nutrition and conditions for cooking – Nutrition of adequate value and in conformity with professed religion is not ensured; appropriate conditions are not created for cooking; inmates are given dirty cutlery.

7. Regarding provision of health care services – Medical case histories do not have entries confirming consent and signatures concerning health check-ups; the number of positions of the staff working in the Health Care Service does not correspond with the number of positions provided for in legal acts; due to vacant positions or part-time employees the Health Care Service may not be able to provide all envisaged health care services; personal health care services are not always available during the night; complaints regarding provision of dental care services are not sufficiently taken into consideration.

8. Regarding provision of information and examination of appeals – Inmates are not appropriately familiarized with their rights and obligations; proper conditions are not created for submission of appeals to the administration of an institution.

9. Regarding special rights – There is no possibility to cover the expenses of third parties for transportation of spouses, both of which are serving a sentence of imprisonment, to a correction house where a long-term meeting will take place and back.

10. Regarding employment, leisure activities and implementation of social rehabilitation – The right to work of the disabled is not ensured; there is a lack of jobs; inmates lack leisure activities out of cells/residential premises; there is a lack of programmes for the development of maternity skills; women inmates are not

prepared for life in the society following the end of their sentence.

Following inspections conducted in imprisonment institutions, 46 recommendations were provided to the management of the Prison Department under the Ministry of Justice of the Republic of Lithuania and inspected institutions. Out of that number, 44 were implemented, and positions are being coordinated regarding the implementation of 2 (two) recommendations.

The Prison Department informed that the following topics had been included into a plan of upgrading of qualifications of the staff of imprisonment institutions in the Training Centre for 2016: work with minors and women, and the use of handcuffs, straitjackets and other restraining means; 12 special certified beds for restraining persons going wild had been acquired and transferred to imprisonment institutions and recommendations regarding their use were under preparation; where possible, searches conducted in imprisonment institutions were filmed; there was a plan to improve legal regulation regarding a penalty imposed on minors, namely, closing them in a disciplinary isolation cell; in 2016, appropriations from the state budget were provided for the installation of wheelchair ramps and adaptation of residential premises of imprisonment institutions for the disabled; there was a plan to initiate amendments of the Penal Enforcement Code concerning the establishment of the procedure for the payment of expenses related to travel to long-term meetings when both spouses served their imprisonment sentences.

Kaunas Remand Prison for Minors – Correction House agreed with all the recommendations issued by the Seimas Ombudsman and drew up a plan for the implementation of the recommendations providing for a timeframe and employees responsible for appropriate implementation of the recommendations.

Kaunas Remand Prison for Minors – Correction House took steps to receive additional staffing positions to ensure appropriate functioning of the Health Care Service; check whether medical case histories contain entries confirming consent of detainees and convicts and signatures regarding health check-ups and prescribed treatment; update information files kept in cells and ensure that informational documentation kept in cells was checked every working day and that the head of the division would stress to his staff the necessity of appropriate familiarization of persons with their rights and obligations as well as amended legal acts during every staff meeting; ensure that each morning everyone willing were registered to a reception with the staff of the administration of the institution and install boxes for submission of appeals; ensure that the staff of the Social Rehabilitation Division provide social services to detainees; ensure that leisure activities are actively pursued with convicts taking them out of their cells. For good behaviour, work and studies inmates are encouraged by trips to events or social campaigns outside the institution; a draft order amending the order of the director of the institution "On Approval of Positive Leisure Measures and Appointment of the Staff Responsible for their Implementation" is under preparation; in 2016, the environment of the institution will be adapted to persons with a physical disability (the installation of wheelchair ramps); in 2016, premises of the institution will be adapted to keeping persons with a physical disability; in 2016, appropriate lighting will be installed in a disciplinary isolation cell; sanitary

units in the institution were repaired; additional hard inventory was bought to detainees and conditions were also created for detainees to make some of it themselves; a check is conducted once a month as to whether persons transferred from the remand prison to the correction home are given hygiene means; clean cutlery is given to detainees; privacy of persons is ensured in cells; additional soft inventory was purchased to detainees.

Panevėžys Correction House agreed with the majority of the recommendations provided by the Seimas Ombudsman and, like Kaunas Remand Prison for Minors – Correction House, drew up a plan of implementation of the recommendations: a part of the premises was adapted to persons with a physical disability, the other part is being prepared for the adaptation; specialists are hired to the positions of the Health Care Service; anonymous survey of convicts regarding the quality of provision of dental care services is conducted; special stamps are placed in medical case histories confirming that a patient has been informed about the treatment plan, understands it and agrees to receiving treatment; all household appliances in kitchens are functioning; a memo about their rights and obligations was drawn up and is handed to women inmates, the memo was also translated into Russian; boxes were placed for submission of anonymous written appeals; there is telephone connection and there is a possibility to make an information call; a penalty isolation cell was installed properly; the right of persons in a disciplinary group to use courtyards for taking a walk was ensured; quarantine premises were repaired; appropriate cleaning of residential premises is ensured; sanitary units were repaired; conditions were provided for women inmates, who had a job, to wash themselves after work; appropriate conditions for keeping clothes and other personal belongings were ensured.

However, two recommendations remained unimplemented. According to the institution, the right to receive health care services during the night is ensured for women inmates, and nutrition of adequate value and in accordance with religious convictions is ensured. It is noteworthy that a dialogue is ongoing regarding the implementation of the two recommendations indicated above trying to achieve their implementation.

Lukiškės Remand Prison – Closed Prison implemented a recommendation of the Seimas Ombudsman and installed a cell adapted for a person with a physical disability; such persons are also provided a possibility to work, if need be.

During 2015, a follow-up inspection was conducted in one imprisonment institution (Marijampolė Correction Home) in order to assess whether recommendations which had been provided during a prior inspection were implemented (5). A follow-up visit revealed that one recommendation had been implemented, while the rest had not been implemented or had been implemented inappropriately, therefore, it was recommended to take measures to ensure that all the recommendations were implemented, and additional recommendations were issued (7) regarding other shortcomings identified during the follow-up visit.

According to the data provided by institutions to which recommendations had been issued, almost all the recommendations were implemented (8) or partially implemented (2): measures were taken to ensure that complaints ad-

dressed to the director of the Correction Home regarding possibly inappropriate behaviour of officers were registered separately; a staff member responsible for the control of drawing up of replies to inmates' complaints was designated; the procedure was approved and persons were designated responsible for elimination of faults of various types and the control of performance of these works; windows were glazed in temporary detention and penalty isolation cells (it was not possible to ensure the established indicator of natural lighting, because that would require the reconstruction of a building). The Prison Department conducted targeted inspections in imprisonment institutions regarding the registration of detainees' requests, applications and complaints, provided recommendations to imprisonment institutions regarding filming of searches and the procedure for keeping records, provided for nutrition of detainees according to a special dietary menu, analysed in detail measures envisaged and performed in 2015 related to recruitment of specialists to health care services of subordinate institutions, and drew up an action plan as to how to fill in vacant positions of health care specialists.

Recommendations following inspections in Imprisonment Institutions

The majority of recommendations addressed to imprisonment institutions were related to filling vacant positions and ensuring dietary or special nutrition for medical indications. Other recommendations were also provided, namely related to appropriate provision of health care services to inmates: there were doubts as to whether inmates were always properly informed of the prescribed treatment and expressed their consent to it; whether persons who were imposed with the solitary confinement penalty were visited by a health care specialist on a regular basis. Particular institutions were also given other recommendations with regard to ensuring appropriate, safe and secure detention conditions, appropriate and sufficient provision of the necessary items, organisation of nutrition, adaptation of premises for the disabled, properly informing inmates of their rights and obligations, organisation of inmates' leisure, training for the staff, etc.

In 2015, the Seimas Ombudsmen assessed the human rights situation in three imprisonment institutions (two correction facilities and one remand prison-closed prison) regarding the human rights situation of vulnerable groups in imprisonment institutions: Lukiškės Remand Prison – Closed Prison, Kaunas Remand Prison for Minors – Correction House and Panevėžys Correction House (20 November 2015 Report No 2015/1-99).

PLACES OF DETENTION AND ACCOMMODATION OF FOREIGNERS

In 2014, the Seimas Ombudsmen assessed the human rights situation in ten places of detention and accommodation of foreigners: the Foreigners' Registration Centre, the Refugees Reception Centre as well as frontier stations of Vilnius and Ignalina Frontier Districts (Gintaras Žagunis, Dieveniškės, Pavoverė, Švenčionys, Adutiškis, Tverečius, Puškai frontier stations and the Headquarters of Ignalina Frontier District).

The following are the main problems and human rights violations identified:

1. Regarding safe, secure and appropriate conditions – In all inspected frontier stations and the Refugees Reception Centre, residential premises were not suitable to persons with reduced mobility, entrances to frontier stations were not adapted to such persons either. Not all places of detention of foreigners ensured cleanness and neatness; in certain places, some of the necessary items were lacking; violations of lighting, heating, ventilation and other hygiene norms were identified. Not all frontier stations had video surveillance cameras installed; in the Foreigners' Registration Centre, safety and security was insufficiently ensured, since only the asylum seekers' dormitory had a newly installed and properly operating electronic security system. As for ensuring safety and security, it should also be noted that, in the Foreigners' Registration Centre, a violation of rights was identified due to the failure to comply with the obligation to accommodate detained foreigners separately from detained asylum seekers, and men separately from women.

2. Regarding ensuring the right to private life and the freedom of religion – It was established that, in the Refugees Reception Centre, sanitary premises were installed without taking into account the specific features of religion professed by accommodated foreigners; the Foreigners' Registration Centre did not always ensure nutrition according to religious or cultural convictions, besides, due to the infrastructure of the Foreigners' Registration Centre, it was not always possible to provide possibilities for persons to practice their religious rites according to the faith professed. Moreover, in the Foreigners' Registration Centre, families were not provided with a possibility to be accommodated separately.

3. Regarding the right to receive information – In the section of unaccompanied minors of the Refugees Reception Centre, there were no information stands, while on other information stands, information was provided only in Lithuanian. In the Foreigners' Registration Centre, data received during the inspection on the information provided on information boards did not reflect the reality. In addition, even though interpretation services were ensured in the Foreigners' Registration Centre, sometimes accommodated persons speak only their mother tongue, a rare language in the European Union, making it problematic to address these persons' everyday issues.

4. Regarding inappropriate management of documents – In the majority of frontier

stations, placement of detained persons into premises of temporary detention was not registered in an appropriate register. In the Foreigners' Registration Centre, the registration of documents related to cases of violence was inappropriate because they were split into two registers. It was also established that, in the Foreigners' Registration Centre, regulation in cases of use of a firearm and special measures was insufficient – official notifications were drawn up inappropriately and medical doctors did not perform check-ups following the use of these measures, which could have resulted in a violation of the principle of proportionality. When providing recommendations to places of detention of foreigners, the majority of remarks were related to the adaptation of residential premises and premises of temporary detention as well as entrances to institutions for the disabled. Many frontier stations were also given a recommendation to ensure appropriate registration of the fact, date and time of placement of detained persons into premises of temporary detention. Frontier stations were also provided recommendations with regard to ensuring the validity of medicinal products and medical aid means kept in medical kits, warnings regarding the use of video surveillance cameras in accordance with the requirements of protection of personal data, and conformity of cells to the requirements of legal acts. As for the Foreigners' Registration Centre and the Refugees Reception Centre, it should be noted that they were given recommendations regarding sufficiency of the necessary items, cleanness, neatness, lighting, heating, ensuring the compliance with safety and security requirements, providing possibilities to exercise the right to privacy (ensuring nutrition and installation of premises taking into account religious and cultural convictions, provision of possibilities for members of the same family to be accommodated together), ensuring appropriate provision of information (including the provision of information in the language understood by persons).

In 2015, the Seimas Ombudsmen assessed the human rights situation in seven places of detention of foreigners: in Vilnius Airport and Kaunas Airport Frontier Stations of Vilnius Frontier District, Tribonys Frontier Station of Varėna Frontier District, Stasylos border crossing point and Šalčininkai border crossing point of Tribonys Frontier Station of Varėna Frontier District and Kapčiamiestis Frontier Station of Lazdijai Frontier District of the State Border Guard Service (12 May 2015 Report No 2015/1-33), and a visit was also made to the Foreigners' Registration Centre of the State Border Guard Service (15 October 2015 Letter No 2015/1-118/3D-2840).

The following are the main problems and human rights violations identified:

Frontier Stations of the State Border Guard Service

1. Regarding registration of persons who are brought in – Registers of persons do not always contain information on whether a person who had been brought in was placed in premises of temporary detention and how long he/she was there, also the date and/or time of delivery or release of a person.

2. Regarding adaptation of premises to the disabled – Premises (including sanitary units installed in the premises) are not adapted to persons with a physical disability, and conditions are not ensured for such persons to access the premises.

3. Regarding ensuring artificial and natural lighting – Insufficient artificial and natural lighting.

4. Regarding health care – Medical aid means kept in first aid kits were past expiry date or there were no first aid kits at all, and in some cases, kits contained not only medical aid means but also medicinal products.

5. Regarding ensuring cleanness in the premises and performance of disinfection, disinsection and deratization – Premises of temporary detention and asylum seekers are dirty, and in the majority of the premises disinfection, disinsection and deratization are not carried out.

Foreigners' Registration Centre of the State Border Guard Service

During the reference period, an inspection was conducted in the Foreigners' Registration Centre of the State Border Guard Service taking into consideration the information which had appeared in the media with regard to possible violations of the rights of persons detained there (regarding such issues as overcrowding of the Centre, residential premises infested with parasites, a possibility of cooking one's food and receiving nutrition according to religious and cultural convictions, organization of additional activities, and a lack of wheelchairs for persons with a disability of mobility).

1. Regarding overcrowding of the Centre – The Centre was overcrowded.

2. Regarding parasites in residential premises – Premises are regularly disinfected against fleas, but it is still not possible to eradicate them.

3. Regarding a possibility to cook one's food and receive nutrition according to religious and cultural convictions – An alternative menu does not ensure nutrition in conformity with foreigners' cultural convictions, and a menu for children is the same as the one for adults. In a building for arrested persons, foreigners have limited possibilities to cook.

4. Regarding a lack of activities for detainees – A social worker employed in the Centre is not able to provide all the necessary social services to all detainees: the services of the social worker are available one hour a day on average.

5. Regarding supply of a wheelchair – A person was provided with a wheelchair, however, he did not have a possibility to move freely around the territory of the Centre.

6. Regarding a possibility to use a phone – Because of the absence of a procedure for using a phone of the Centre, a possibility to use a phone for detainees is not appropriately ensured.

Following conducted inspections, 14 recommendations were provided to responsible institutions. Out of that number, 9 were implemented, while the implementation of the remaining five was started.

Recommendations following inspections in Places of Detention and Accommodation of Foreigners

Recommendations related to frontier stations of the State Border Guard Service were fully implemented: officers record the date and time of delivery and release of persons as well as the fact of placement into premises of temporary detention; if a disabled person arrives, appropriate mobility is ensured without prejudice to such a person's rights and lawful interests; artificial lighting in accordance with the requirements was installed; appropriate first aid kits were acquired; order and cleanness are controlled.

The Foreigners' Registration Centre agreed with all the recommendations provided by the Seimas Ombudsman; with regard to some of them, the Centre provided for a certain implementation period (due to funding and other circumstances): persons are ensured the minimum living space; wide-scope disinfection of premises and personal-use inventory is regularly carried out in the premises; according to possibilities, persons are ensured nutrition taking into account their religious and cultural convictions; the nutrition norms for children are higher; efforts are made to continuously increase leisure activities organized for detainees; persons with a physical disability are accommodated on the ground floor which has a wheelchair ramp; a schedule for using a payphone was drawn up (it is also allowed to use a payphone at another time).