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The Seimas Ombudsmen's Office

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REPORT ON NATIONAL
PREVENTION OF TORTURE



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Introduction

The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (hereinafter referred to as “the Optional Protocol”) adopted by the United Nations General Assembly on 18 December 2002 has reaffirmed that the protection of persons deprived of their liberty against mistreatment can be strengthened by regular inspections of places of detention. This way a system has been established to enable regular visits by representatives of independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment. Following the ratification of the Optional Protocol by the Seimas on 3 December 2013, the Seimas Ombudsmen have been obligated to conduct the national prevention of torture at places of detention and pay regular visits to them, while the Seimas Ombudsmen’s Office has been designated a national preventive mechanism.

The year 2016 has been the third year of the national prevention of torture by the Seimas Ombudsmen. Regular visits to places of detention have proved that the activities preventing torture and other violations of human rights are important and help to achieve positive results: the veil of secrecy is lifted from the institutions, attention is paid to potential problems and aspects which can determine violations of the rights of detained persons, and a progressive and respectful approach is promoted in pursuit of a long-term objective, in particular to ensure that the rights of individuals held in places of detention are not violated.

The preceding year was important to the Seimas Ombudsmen’s Office, since in performing the function of the national prevention of torture, the Seimas Ombudsmen focused on the defence of the rights of vulnerable social groups. For example, the solution of mental disability

problems became one of the key priorities in commemorating the decade of the Optional Protocol to the Convention on the Rights of Persons with Disabilities and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. On the initiative of the Seimas Ombudsmen, in 2016 the International Ombudsman Institute organised international training in Lithuania for employees of European ombudsmen institutions with the aim of improving the skills of human rights monitoring at mental institutions.

The following report gives an account of activities of the Seimas Ombudsmen carrying out the national prevention of torture, the methodology for performing its functions, the inspections conducted, the critical systemic problems identified, the recommendations issued, and the information on the implementation of the recommendations provided.

Powers of the National Preventive Mechanism

Pursuant to Article 191(4) of the Law on the Seimas Ombudsmen, when implementing the national prevention of torture, the Seimas Ombudsmen enjoy extensive powers, in particular the right to:

- choose the places of detention they want to visit and the persons they want to interview;
- have access to all places of detention and all premises located therein;
- have access to all installations and infrastructure of such places and premises;
- have private interviews with the persons deprived of liberty without witnesses, as well as with any other person who may supply relevant information;
- carry out inspections of places of detention accompanied by selected experts.

Inspections are organised during visits to any location where persons are or may be deprived of their freedom, i.e. police custody facilities, imprisonment, care or mental institutions, institutions for the treatment of infectious diseases, institutions for holding or accommodating foreigners, etc.

The Seimas Ombudsmen are assisted by employees of the Seimas Ombudsmen's Office in organising and conducting the activities of the national prevention of torture assigned to them. In performing this function, they pay regular visits to places of detention and conduct their inspections, with a view to identifying any torture or other cruel, inhuman or degrading treatment or other violations of human rights, and supervise the implementation of the Seimas Ombudsmen's recommendations in the field of the national prevention of torture, and carry out other functions assigned to them.

Methodology for Performing 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, in-depth and follow-up inspections are carried out. The national prevention of torture by the Seimas Ombudsmen in 2016 involved questionnaire-based, thematic and follow-up inspections.

AN IN DEPTH-INSPECTION

An in depth-inspection is a comprehensive, carefully worked out, detailed and thorough evaluation of human rights and freedoms. No such inspections were carried out in 2016 due to extensive time required for an in depth fact-finding and evaluation. However, a number of in-depth inspections are planned to be carried out in 2017.

QUESTIONNAIRE-BASED INSPECTIONS

Questionnaire-based inspections represent the filling in of questionnaires adapted to each institution and covering the most important issues related to the living/detention conditions, nutrition, health care, ensuring security and suicide prevention, use of special, restrictive and disciplinary measures, guaranteeing personal independence, provision of information and investigation of complaints. These questionnaires are prepared with account of the requirements set out in national and international legislation, as well as the standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment which has conducted the prevention of torture in the European states for 25 years already.

In 2016, questionnaire-based inspections were carried out at adult care institutions (16), police custody and long-term/temporary detention

facilities (4), and places for the detention of foreigners (3), a total of 23 questionnaire-based inspections.

THEMATIC INSPECTIONS

During thematic inspections, the focus is on a particular sphere(s), for example, the issues of providing health care services, creating a general climate of security, preventing smoking and alcohol consumption, imposing penalties and personnel issues, or on particular persons, for example, groups of vulnerable individuals (women, minors and persons with physical disabilities), or on recommendations made by international institutions, etc.

During the reporting period, seven thematic inspections were carried out at the following institutions: Alytus Correction House, Prienai Care Home, Rokiškis Mental Hospital and four care homes in Kaunas County.

The thematic inspection at Alytus Correction House, a detention facility, evaluated whether proper living/detention conditions, security, the right to information submission of appeals as well as access to health care were ensured for the detainees. Thematic inspections were also conducted at the children's homes of Kaunas County, dealing with the issues of ensuring the sufficient number of employees, a secure environment, the treatment of children by the employees and protection against improper treatment, the application of disciplinary measures, the development of social skills, the organisation of leisure, the introduction of the children to their rights and duties, and availability of information.

Thematic inspections are also carried out in response to any information in the public domain relating to events at places of detention. Where

information is available or reasonable doubts arise about any alleged violations of the rights of detainees, a decision may be taken to monitor the human rights situation at an appropriate institution. In 2016, such an inspection was carried out at Prienai Care Home in response to the media information on a tragedy that had occurred in December leading to the death of a bedridden female resident (the woman had smoked in bed and caused fire, resulting in her suffocation), and on receiving two anonymous complaints (on 9 and 12 December 2016) about the alleged violations of the residents' rights at that institution.

The Seimas Ombudsmen's Office also contributes to the implementation of international commitments assumed by the Republic of Lithuania. In September 2016, a visit was held to Rokiškis Mental Hospital, with a view to evaluating the readiness of the institution to improve its activities with account of the preliminary recommendations made by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as "the European Committee for the Prevention of Torture" or "CPT") after the visit of its members at that institution.

FOLLOW-UP INSPECTIONS

Follow-up inspections are intended to find out the results of implementation of the Seimas Ombudsmen's recommendations, as the follow-up on their implementation is a very important aspect of the national prevention of torture which allows identifying whether the recommendations were implemented and what particular actions were taken to implement them. In 2016, the Seimas Ombudsmen conducted 17 follow-up inspections at different places of detention:

10 adult social care homes, three imprisonment institutions, two police stations, one mental hospital and a facility for the detention of foreigners.

Preparation for the above inspections included a review of the requirements laid down in legislation, case law, as well as the standards of the European Committee for the Prevention of Torture and its reports produced after the visits to Lithuania, collecting the material about institutions subject to inspection. The planned inspections were not notified in advance.

When carrying out any of the above-specified inspections, officials deal with the management, administration and other employees of institutions, as well as with detainees and, where possible, also with their close relatives. They also inspect various premises (both personal and common), evaluate their equipment, get access to the infrastructure of an institution, and check different registration logs and other documents.

On inspecting several places of detention of the same type, reports are drawn up which, based on facts in respective spheres, describe the identified systemic violations of human rights, and note best practice applied at institutions for the purpose of improving the persons' living/detention conditions. Reports produced following the monitoring of the human rights situation state the shortcomings observed during the inspections, give their legal assessment, draw appropriate conclusions and present recommendations for eliminating those shortcomings.

The submission of inspection reports and effective recommendations to the responsible authorities is an essential part of the preventive activities carried out by the Seimas Ombudsmen. Reports with the said recommendations are submitted to the heads of institutions that have

undergone inspections and, where appropriate, to other responsible authorities. It is noteworthy that, pursuant to Article 191(6) of the Law on the Seimas Ombudsmen, the competent authorities must examine proposals/recommendations of the Seimas Ombudsmen, consult with the Seimas Ombudsmen on possible implementation measures of their proposals/recommendations and inform the Seimas Ombudsmen about the results of implementation of their proposals/recommendations. All reports on inspections at places of detention are published on the website of the Seimas Ombudsmen's Office.

While performing the national prevention of torture, it is crucial to engage experts with special knowledge and competence who can evaluate the situation using their expertise based on practical skills. The procedure for the involvement of experts in inspections at places of detention is regulated by the Rules of Procedure for Inclusion of Experts in Inspections of Places of Detention approved by Order No. 1V-41 of the Head of the Seimas Ombudsmen's Office of 24 August 2015. Experts who have undergone introductory training at the office and received a monitoring brochure are entered in the Roster of Experts for Inclusion in Inspections of Places of Detention. An Expert Paid Services Contract is signed with experts (the form of the Contract was approved by Order No. 1V-42 of the Head of the Seimas Ombudsmen's Office of 24 August 2015). In 2016, external experts were involved six times while conducting inspections at mental institutions, children's care homes and a place of imprisonment for persons with disabilities.

Regular meetings with the responsible authorities are held as part of the function of the national prevention of torture. These meetings present the national prevention of torture conducted by the

Seimas Ombudsmen at different places of detention and the most urgent problems identified in 2014–2016, and discuss ways for solving them. Over the reporting period, meetings were held with members of the Council of Rūpestinga globa, an association of the heads of Lithuanian care institutions, the heads of care institutions and other representatives of the responsible authorities in the counties (Kaunas and Klaipėda), and psychiatrists' representatives with regard to the proper safeguarding of human rights standards in psychiatry, as well as with representatives of the Ministry of Justice of the Republic of Lithuania and the Prison Department under the Ministry of Justice. Also a meeting with the CPT, the Ministry of Justice and the Ministry of the Interior of the Republic of Lithuania was organised. Moreover, three qualification development seminars under the title "Ensuring human rights and freedoms in the functions of police officers (for persons placed under police supervision in police custody and temporary detention facilities, or in escorts)" were organised (in Vilnius, Kaunas and Klaipėda Counties).

While performing the function of the national prevention of torture, ensuring inter-institutional cooperation is of importance as well. Therefore in 2016 the Seimas Ombudsmen cooperated with the Office of the Ombudsman for Children's Rights of the Republic of Lithuania during visits to children's care homes, the representatives of the United Nations Refugee Agency (UNCHR) in Lithuania and other institutions.

STAGES OF INSPECTIONS

The stages of inspections to places of detention include the following stages:

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 feedback 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 noted 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 191 (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 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.

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.

Inspections Conducted at Places of Detention

During the reporting year, the Seimas Ombudsmen conducted inspections at 47 (forty-seven) places of detention in total, including:

- 27 (twenty-seven) at adult care institutions (16 questionnaire-based, 10 follow-up and one thematic);
- 6 (six) at police custody and long-term or temporary detention facilities (four questionnaire-based and two follow-up);
- 4 (four) at detention and accommodation facilities for foreigners (three questionnaire-based and one follow-up);
- 4 (four) at children's care institutions (thematic);
- 4 (four) at imprisonment institutions (one thematic and three follow-up);
- 2 (two) at mental institutions (one thematic and one follow-up).

The majority of the inspections or 23 were questionnaire-based ones, followed by seven thematic inspections. Great attention was devoted to the follow-up inspections totalling 17.

On completing the inspections in 2016, a total of 122 recommendations were drawn up, of which 46 were addressed to the adult care institutions, 25 to the children's care institutions, 27 to the police stations, 14 to the imprisonment institutions and 10 to the foreigners' detention and accommodation facilities.

Of the above-mentioned recommendations, eight ones were concerned with the improvement of legal acts. Also 98 recommendations were drawn up after follow-up inspections.

It is important to note that in 2015 the Seimas Ombudsmen had assessed the human rights situation at nine care institutions in Panevėžys County (for elderly people). However, in the process of preparing the annual report (2015) of the Seimas Ombudsmen, no information had been available on the implementation of these inspections. For this reason, the information is included in the 2016 report of the Seimas Ombudsmen. A total of 51 recommendations had been issued.

The Seimas Ombudsmen's activity report for 2015 described the shortcomings identified by the inspections at 4 (four) children's care institutions of Vilnius County. The responsible authorities were provided with 24 recommendations in total.

Most of the Seimas Ombudsmen's recommendations were implemented (fully or partially), or the Seimas Ombudsmen were supplied with plans on their implementation in the future: 70 recommendations were implemented after the questionnaire-based inspections, and cooperation is continued with the responsible authorities on the implementation of the remaining recommendations.

The Report further presents the problems identified during the visits and the recommendations provided to the responsible authorities with respect to the elimination of these shortcomings and the progress achieved in implementing the recommendations.

Most important systemic problems identified

SOCIAL CARE INSTITUTIONS

Social care institutions for adults

In 2016, the Seimas Ombudsmen assessed the human rights situation at 17 (seventeen) social care institutions (for adults with disabilities and elderly persons):

- 10 (ten) care institutions in Šiauliai County: Aukštelkė Social Care Home, Beržėnai Old People's Home, public establishment Senolių namai, Šiauliai City Municipality Care Home, Linkuva Social Services Centre, public establishment Old People's Home Santara of Joniškis Parish of St. Mary the Virgin, private limited company Senjorų namai, Šėduva Care Home, Old People's Home of Rozalimas Parish of St. Mary the Virgin, and state-funded enterprise Lioliai Social Care Home (Report No. 2016/1-40 of 20 July 2016);
- 6 (six) care institutions in Klaipėda County: public establishment Caritas Klaipėda Regional Care Home of Telšiai Bishopric, public establishment Skuodas Care Home, public establishment Ylakiai Care Home, state-funded enterprise Klaipėda City Care Home, Palanga City Care Home, and Vilius Gaigalaitis Care Home (Report No. 2016/1-40 of 20 July 2016);
- Prienai Care Home (Report No. 2016/1-116 of 30 December 2016).

Summing up the circumstances identified during the inspections, the following most common main violations of human rights have been distinguished:

1. Concerning the organisation of meals. No conditions are provided for the use of all

cutlery during meals, and no proper conditions for cooking food independently exist. The menus are compiled by employees who have no appropriate education, while the menus themselves are in the format difficult to read for the residents. In addition, the residents have no opportunities to submit their wishes with regard to foodstuffs and the mix of dishes in advance. Nor are the residents properly urged to drink water either.

2. Concerning the provision of personal health care services. The institutions have no valid licenses and permits/hygiene passports to provide personal health care services. Medicines are brought to the residents by the personnel that have no required special training for that. Consent with the treatment prescribed by a doctor to a resident is expressed orally rather than in writing, while some female residents receive allegedly unjustified and unreasonable health care services. In addition, the residents have no conditions for refusing the treatment prescribed to them. The care institutions keep medicinal products with dates expired, including the uncontrolled storage and use of medicines by the residents. Information about the residents' health condition and other related data are stored inappropriately. The residents have to buy the medicines with their own money or cover at least part of their price, as they are not always informed of the possibility to obtain them free of charge.

3. Concerning the right to privacy and data protection. Employees do not knock on the door before entering the residents' rooms, and the residents have no opportunity to lock their rooms. Where such an opportunity is provided,

several residents of the same room have to share one key. Also privacy is not ensured in the hygiene facilities. The residents have no possibility to keep their personal belongings in separate lockable closets, and their residential rooms lack private spaces. In addition, there is a lack of the home environment. Folding screens are not always present during personal hygiene procedures of nursed residents and no folding screens whatsoever are used for a doctor's consultation/examination of a resident in his/her room. Such consultations/examination are also attended by the community nurse of an institution.

4. Concerning social work. No individual social care plans (ISCP) are drawn up or such plans are not reviewed within the set time period. Moreover, ISCPs are prepared without a resident or his/her representative attending, and the plans are not made available to residents against signature. Some ISCPs lack signatures of their developers. The care plans lack periodic entries about a person's health condition or achieved results, evaluation of the need of new services or measures foreseen with respect to meeting the changed needs. Residents are not introduced to plans, schedules or programmes of social activities (prevention of addictions, leisure or employment). There is also a lack of planning, systematisation and consistency of social work with the residents.

5. Concerning the ensuring of security. The emergency call system (ECS) is either missing or not fully installed, and fire safety is not ensured in full.

6. Concerning other shortcomings identified. The inspections have also found that the possibility for the free movement of residents in a care home and its territory is not adequately ensured. The anonymity of requests is allegedly not ensured. Also the residents are bathed once during more than seven

days and their underwear is not changed on a daily basis. Ventilation and everyday cleaning of the premises is ensured insufficiently.

On completing the inspections at 16 adult social care institutions in Šiauliai and Klaipėda Counties, a total of 26 recommendations were issued, including 3 for the Social Services and Care Department under the Ministry Social Security and Labour (one concerning the improvement of legal acts), 23 for the heads of the inspected care institutions, of which 19 for the adult social care institutions of Klaipėda County, and 23 for 23 Šiauliai County. After the inspection at Prienai Care Home, 20 recommendations were made in total, of which one was for the Prienai Fire Service of the Kaunas County Fire Rescue Administration and 19 for Prienai Care Home.

When providing information on the implementation of three recommendations, the Social Services and Care Department indicated that the recommendations had been taken into account and that all social care institutions for adults with disabilities and the elderly had been advised to take measures to ensure the human right to privacy in the social care homes.

The social care institutions operating in Klaipėda County implemented almost all the recommendations issued to them: of the total of 19 recommendations, 12 ones were implemented in full and seven ones in part. No recommendations were left unimplemented. The recommendations implemented in part were concerned with the delivery of medicines and all other related procedures to the residents by the competent personnel, the provision of information to the residents about their supply with all the required medications prescribed by a doctor, the knocking by the staff before entering the residents' rooms, the possibility for persons to lock

themselves in their personal residential premises depending on the residents' independence, the possibility for residents to keep their personal belongings in separate lockable closets, and the ensuring of privacy in personal hygiene facilities.

The social care institutions of Šiauliai County implemented all the 23 recommendations provided. It is noteworthy that four care institutions supplied information on the results of implementing the recommendations by phone; therefore they were instructed to provide this information also in writing.

Thus the Šiauliai and Klaipėda care institutions implemented in full or in part all the 26 recommendations issued. No information on the implementation of recommendations given on completing the inspections at Prienai Care Home has been received yet.

In 2015, the Seimas Ombudsmen had assessed the human rights situation at nine care institutions (for the elderly) in Panevėžys County. In the process of drawing up the 2015 Report of the Seimas Ombudsmen, no information on the implementation of recommendations had been obtained. As a result, this information is provided in the present Report.

On completing the inspections at the care institutions of Panevėžys County, 51 recommendations were presented in total: 4 for the Ministry of Social Security and Labour, 3 for the Panevėžys District Municipality and the Panevėžys Bishopric Curia, Pasvalys District Municipality, Kupiškis District Municipality, Biržai District Municipality, Biržai Parchy of St. John the Baptist, Nemunėlio Radviliškis Parish of Evangelical Reformers and Nemunėlio Radviliškis Parish of St. Mary the Virgin, 45 for the inspected care institutions, 1 for the Panevėžys

County Fire Rescue Administration and 1 for the State Health Care Accreditation Agency under the Ministry of Health.

The State Health Care Accreditation Agency under the Ministry of Health implemented the recommendation given to it, and carried out non-routine control on the quality of personal health care services at Legailiai Social Care Home of Biržai district.

Out of the four recommendations, the Ministry of Social Security and Labour implemented two ones: it will organise training for the personnel engaged in social work and look for possibilities to allocate additional financing to qualification development events for employees of care institutions. However, the other two recommendations were left unimplemented: no attention was devoted to the fact that the minimum number of the personnel engaged in social work was insufficient in case of employees' illness, vacation, etc. Nor any possibilities were sought to increase the salaries of employees of the social care institutions.

The Panevėžys County Fire Rescue Administration implemented the recommendation and conducted fire safety technical checks concerning alleged violations at the care institutions of Panevėžys County.

The Panevėžys District Municipality, Panevėžys Bishopric Curia and Kupiškis District Municipality implemented the recommendation of the Seimas Ombudsmen, while the Pasvalys District Municipality, Biržai District Municipality, Biržai Parish of St. John the Baptist, Nemunėlio Radviliškis Parish of Evangelical Reformers and Nemunėlio Radviliškis Parish of St. Mary the Virgin failed to take into account the recommendation issued to them. Therefore

at present a discussion is under way with the above entities on the implementation of this recommendation.

Of the recommendations issued, the care institutions implemented all 45 of them, except one care institution (public establishment Ona Milienė Old People's Home) where nine recommendations were implemented in full or were not implemented at all, in particular those regarding the nurse's position of the scope below the standard, the shortage of personnel during illness or vacation, development of employees' qualifications, increase of the minimum salaries of the personnel, internal reconstruction of the building (broadening of the stairs and installation of a lift and fire escape ladder for fire emergencies), adaptation of the window height to bedridden and/or sitting residents, purchase of the necessary new furniture, creation of a home-like environment and hiring of an employment specialist. The care institution indicated that the above measures had not been implemented, as they required large investments. However, the Seimas Ombudsmen are continuing the discussion with this care institution for the purpose of achieving the implementation of all the recommendations and preventing the use of the money issue as an argument that allows violating human rights.

Social care institutions for children

Also inspections were conducted at 4 (four) children's care institutions in Kaunas County: the Kaunas Municipality Children's Care Home, Kėdainiai Children's Care Home Saulutė, public establishment Paparčiai St. Joseph's Family Home and Children's Home Namų židinys of the foundation Parama vaikui (Report No. 2016/1-88 of 20 December 2016).

The following main problems and most common violations of human rights have been identified:

1. Concerning the composition, number, workload and salary of the personnel. The number of employees is inadequate in case of personnel's illnesses, vacation, etc. The workload of social workers and their assistants is large, and their small salaries contribute to the great turnover of the personnel. Some complaints have been received that a psychologist is not capable of providing the required help to all children, has ignored their needs and betrayed someone's secret to other children. The children in care have no trust in him and believe that a psychologist is only necessary for patients suffering from a mental disease.
2. Concerning the qualification development. Social workers lack practical training on preparing for emergency situations and their control; persons responsible for the personnel's qualification development are not aware of the preferences of employees with regard to improvement of their qualifications. There is also a shortage of funds for paid events on the qualification development of the personnel.
3. Concerning the treatment of children by employees. Complaints have been received on the treatment of children that involved shouting, angry speech, preconceived judgment with respect to children or slander about the parents, or on the failure to notice children's proper behaviour.
4. Concerning the disciplinary measures applied and control of the children's behaviour. The procedure for the application of punishments lacks an exhaustive list of measures applicable to children, a time frame for applying punishment and the requirement of proportionality or this requirement is sometimes not complied with. The reduction or complete withdrawal of pocket money is quite

often applied as a disciplinary measure. In some cases, when left in charge of younger children, older children themselves would discipline them for the inappropriate behaviour.

5. Concerning the events of a negative nature. The perception of cases that are considered events of a negative nature differs. No registration log of such events is kept, or not all negative events are entered in such a log.

6. Concerning the living conditions. No proper conditions for doing homework were provided. Children were living in a room of a very poor condition and without a door. Children complained about the lack of privacy when a roommate (mostly an older person) would bring a boyfriend or a girlfriend to the same room or play music at full volume.

7. Concerning the ensuring of personal hygiene items. The purchase of such articles does not meet the children's individual needs or ensure the possibility to express their opinions. The supplies (cups, towel holders, etc.) in the hygiene rooms are marked with numbers (rather than child's name or a symbol agreed with a child in care). Not all the children had oral hygiene items appropriate for their age.

8. Concerning the procedure for payment of pocket money. The legal framework breaches the principle of equality where children of similar age get different sums of pocket money at different institutions. Fourteen-year-olds receive not the full sum due to them, i.e. the payable amount of 15.20 euros is rounded down to 15 euros. The procedure for payment of pocket money is not clear, and there is no indication about how and for what actions the sum of pocket money can be increased, reduced or not paid at all, which creates preconditions for an institution to abuse its rights when allocating and paying pocket money.

9. Concerning the introduction of children to their rights and duties, availability of information and examination of inquiries. The availability of information is only ensured in part, and the anonymity of inquiries is not guaranteed.

10. Concerning the prevention of smoking and alcohol consumption. The efforts to solve the issues of preventing the consumption psychoactive substances, identifying the fact of their consumption and providing assistance to children are inadequate.

Regarding the above shortcomings, a total of 25 recommendations were made to the responsible authorities (of which one was concerned with the improvement of the legal framework). No information has been received yet on the implementation of those recommendations.

The 2015 Report of the Seimas Ombudsmen described the shortcomings found during the inspections at 4 (four) children's care institutions of Vilnius County, in particular Antakalnis Children's Social Care Home, Children's Social Care Home Gilė, public establishment Social Centre for Children and Adolescents, and Mintis Children's Social Care Home (Report No. 2015/1-137 of 29 February 2016): concerning the composition, number, working hours and salaries of the personnel, personnel qualification development, volunteer activities, general safety climate at the institutions, improper treatment of children by employees, disciplinary measures applied and control of children's behaviour, procedure for payment of pocket money and other issues. With respect to these shortcomings, a total of 24 recommendations were issued to the institutions (of which two ones were concerned with the improvement of the legal framework). However, no information was obtained about

their implementation at that time yet. The information provided by the above institutions in 2016 shows that all the recommendations issued by the Seimas Ombudsmen have been implemented.

The Ministry of Social Security and Labour has informed that an amendment has been made to the Guidance of Social Care Standards providing for a uniform amount of pocket money to be set for children of the same age group (except children with disabilities) at a social care institution, and guidelines for volunteer activities at children's care homes and a sample volunteer activity contract have been drawn up and forwarded to all children's care institutions; training on the application of methodological packages for the identification of individual needs of target groups residing at care institutions and the development of individual plans for them has been organised, and workers of social care institutions have used these methodologies to assess the needs of children, including those with behavioural and emotional disorders, those needs to serve as the basis for the delivery of specialised services (early rehabilitation of developmental disorders, health care, consultation services, etc.). The promotion of the change of society's values intended for the development of a tolerant and open community is one of the aims of reform (transition from institutional care to services provided in a family and community). Thus measures have been taken to change the stigmatising public attitude towards children in social care, including social advertisements in public transport and community events, the preparation of a strategy for integrated communication with society (August 2016), and the development of a system designed for reform (the website www.pertvarka.lt, intranet and email). The Department of Supervision of Social Services has confirmed that, in the

process of assessing the quality of services at the children's social care homes, particular attention will be devoted to the shortcomings specified in the inspection reports.

The Vilnius City Municipality Administration has supplied the information that the care institution seeking to ensure the appropriate organisation of social work can always apply to the administration's Social Affairs and Health Department for the agreement of a new job list to increase their number; funds were allocated for the development of personnel's qualifications in the 2016 budget for all institutions inspected by the Seimas Ombudsmen; an Intensive Care (Correction) Centre is being organised for children with emotional and behavioural disorders (expected to be launched in March or April 2017, with a two-year care duration); an agreement has been signed with the Charity and Support Fund Žiburys on the search for, selection, consultation of and support for carers (custodians) and adoptive parents in Vilnius City, coupled with the dissemination of good examples, formation of a positive approach towards the custody of children in a family and the organisation of public events; also the Education Division and the Health Care Division of the municipality's Education, Sports and Culture Department have been requested to discuss a problem at meetings with the heads of the institutions under their control and take measures to formulate an objective attitude to children residing in care homes. The Association of Local Authorities in Lithuania has also noted the fact that children from care institutions suffer from a stigmatising approach in local communities and has indicated that appropriate actions will be taken as soon as practicable.

The Ministry of Health has approached the personal health care institutions with a request to

organise measures for reducing the employees' negative attitude to patients from children's care institutions, strengthen cooperation with them and provide detailed information to patients on their rights and duties. The Ministry of Education and Science has informed the Education Divisions of the municipalities and the National Agency for School Evaluation about the circumstances identified in the Report with respect to the stigmatising approach of the educational establishments towards children in care and requested the principals of schools on the elimination of any intolerance to any form of discrimination, respect of schools for the principles of ensuring equal opportunities, the meeting of different educational needs of children with account of their level of learning and achievements, learning capacity and skills, maturity and mental and physical characteristics, as well as the provision of effective educational assistance to schoolchildren, cooperation with parents (carers, custodians) and the creation of a general microclimate favourable to the school community.

The institutions have taken measures to implement the recommendations issued to them: they have employed psychologists, found out which employees treated children inappropriately, issued oral comments and notices and provided specialised services to children with behavioural and emotional disorders (established closer contacts with relatives, found carers for weekends, included children in the foreign visit programme, provided the service of an assistant teacher and art therapy, organised visits to day centres, increased the number of clubs, volunteers, etc., and approached the founder with respect to the additional positions of a psychologist and a special pedagogue and the funds for psychotherapist's services). The

employee qualifications are improved continuously, and a psychologist comes to assistance in solving the problems, with a view to preventing any stigmatising approach towards children in care. The institutions have also cooperated with educational and health care establishments, as well as with the local community (in organising events, etc.). A procedure for the assignment and application of punishment for improper behaviour has been approved, and preventive discussions have been held with older children about their failure to discipline smaller children. The reduction or withdrawal of pocket money is not applied as a disciplinary measure or is applied in extreme cases, the allocation of pocket money to all children is ensured and training/discussions on the rational use of pocket money are conducted. A "Small Euro Day" is organised when children and social workers go to shopping centres where they get familiar with prices, promotion campaigns and health products, and are taught to make the correct choice. More attention has been devoted to education on the consumption of psychoactive substances (a plan of measures, as well as more events and classes have been provided for); children are supplied with the necessary hygiene items and other necessary things with account of their age, gender and other circumstances; if possible, children's opinions are taken into consideration; the belongings of each child are marked with symbols; proper conditions are provided for doing homework; the missing supplies are replenished; the leisure activities are not divided by the gender and account is taken of the children's comments on the quality of clubs and their preferences; and the anonymity of children's inquiries is ensured (identical envelopes distributed to families are freely accessible, children throw them into a post box,

and employees sign a confidentiality agreement on non-disclosure of child information and the content of individual conversations); also group and individual conversations are initiated for the purpose of discovering various shortcomings.

POLICE CUSTODY FACILITIES

During the reporting period, the assessment of the human rights situation at custody and temporary detention facilities of police stations included inspections of the custody and temporary detention facility of the Klaipėda County Police Headquarters and 3 (three) police stations in Klaipėda County, in particular Plungė District Police Station, Skuodas District Police Station and the long-term and temporary detention facilities of Palanga City Police Station (Report No. 2016/1-21 of 8 June 2016).

The following main problems and most common violations of human rights have been identified:

1. Concerning the officers' working conditions. The officers' working facilities (their part) are non-renovated, i.e. the floor and wall cover is worn out, the ventilation system is installed inadequately, no conditions for washing oneself exist, and there is a lack of a sports hall.

2. Concerning the detention conditions and supply of persons. The detention facilities are not adapted to persons with movement disabilities and fail to meet the statutory requirements for the floor area, ventilation and lighting. The long-term detention facilities have double deck beds, which creates conditions which can give rise to a threat that the living conditions of persons detained in such premises may be equivalent to degrading treatment due to the lack of personal space. The supplies provided for in laws, in particular individual closets and coats hooks, as well as the cleanliness are not ensured. The detained persons

are not supplied with mattresses and blankets when staying in temporary detention facilities during night-time. The privacy of detainees is not ensured in the use of the sanitary facilities (the surveillance cameras are installed so as to show a part of the space the sanitary facilities which also lack doors); persons under the influence of alcohol are held in temporary detention facilities longer than the 5-hour time limit; persons held in long-term detention facilities for 24 hours or more have no opportunity to go for a walk outside; not all police stations had clothing which, if necessary, could be provided to disinfected persons in custody facilities; individuals held in custody facilities have no appropriate conditions for washing their personal outer garments and bedding and drying them afterwards.

3. Concerning the organisation of meals and health care. Minors get three meals a day, without observing the time intervals defined in laws; the food from catering services providers served to detainees is not checked; officers who distribute meals have not completed compulsory training in hygiene skills, and have failed to comply with the hygiene requirements while distributing food; preconditions are created for violating the privacy of persons during their examination by health care professionals in cells (also with other detainees present in a cell) or hallways by the cells; the dates of medicines in the first aid kit at the duty officers' unit were expired.

4. Concerning the right of access to information for persons, including foreign nationals. The custody and long-term detention facilities have no internal rules of procedure displayed; persons are not introduced with their rights and duties at long-term detention facilities against signature; and no internal rules of procedure for custody and long-term detention facilities have been prepared in any foreign language.

5. Concerning data registration. The data on the placement of persons in temporary/long-term detention facilities are not recorded or are recorded inappropriately; the narrow monitors show not all the options of the Electronic Register, which prevents the full use of this software.

On completing the inspections at four police stations, 27 recommendations were provided to the responsible authorities, including the Police Commissioner General of the Republic of Lithuania, the chief of the Klaipėda County Police Headquarters and the Ministry of Health of the Republic of Lithuania (of which three recommendations were concerned with the improvement of the activities of the police custody facilities and the legal framework of the public health care). Most of the recommendations (23) were implemented in full or in part.

In its reply regarding the implementation of the provided recommendations, the Police Department indicated that the hardware and software present at the institutions under the Department was constantly upgraded where possible, with a view to ensuring the use of the Electronic Register to the full extent, and that the legal framework was being improved by including in the internal rules of procedure of the police custody facilities a provision on the supply of clothing and footwear in case detainees had no garments of their own or were not dressed for the season.

The Klaipėda County Police Headquarters has informed that surveillance cameras have been installed not only in custody cells but also in interrogation rooms; the food supplied to detainees in custody facilities is checked two to three times a month and it is distributed by employees of the catering services provider; in case disabled persons have to be detained, they are brought to the facilities adapted for this purpose at the

Klaipėda County Police Headquarters; the working, temporary detention and interrogation facilities of the operational group at the Palanga City Police Station have been equipped with a ventilation system, and in the working facilities of the operational group of the Plungė District Police Station this system has been renovated; doors have been installed in the sanitary facilities of the Palanga City Police Station to enable the persons' private use of the toilet; the Police Stations of Plungė and Skuodas districts have been outfitted with shower rooms, and new vandal-resistant lights have been installed and contracts on the lease of sports facilities have been concluded at the Plungė District Police Station; the Skuodas District Police Station is using its own sports hall; the police stations have been equipped with additional dispensers for disinfection liquids; the chief of the Klaipėda County Police Headquarters has issued an order on the procedure for the placement of detainees in the temporary detention facilities and their transfer to the custody facilities, which has been made available to the officers; persons detained at the police stations of Palanga, Plungė and Skuodas districts are held for not more than five hours, thereby solving the issues of ensuring the necessary supplies and walks, privacy, organisation of meals and provision of information; information folders for detained have been prepared following the approval of the new internal rules of procedure for the police custody facilities, and their translations into foreign languages will be provided as well.

Four recommendations of the Seimas Ombudsmen have not been implemented: due to the existing structure of the building, there is no possibility for enlarging the temporary detention facilities at the Plungė District Police Station; and the recommendation to provide appropriate conditions for washing and drying personal outer

garments and bedding at the custody facilities of the Klaipėda County Police Headquarters has not been implemented either. The Police Department disagreed with the recommendation to supply persons placed in temporary detention facilities during night-time with soft items such as mattresses and blankets, and has failed to implement the recommendation to take measures to prevent the violations of human rights also at other police institutions identified during the inspections. The Ministry of Health disagreed with the proposal to improve the health care regulations, expressing the opinion that the existing legal framework was sufficient (in particular the List of public health measures implemented by the state-funded closed health care institutions of the Ministries of the Interior and Defence, Lithuanian Medical Standard MN 129:2004 "Medical unit (office) of the custody facilities at a territorial police institution" and the Regulations on the operation of custody facilities at police stations).

The recommendations of the Seimas Ombudsmen that have not been implemented or rejected by the responsible authorities are analysed further and ways for solving the problems are sought in order to improve the human rights situation at the police stations.

The Seimas Ombudsman has also requested the Ministry of Health to provide information on the results of work to solve the question of an inter-service working group for the delivery of persons under the influence of alcohol to an appropriate (police, personal health care, etc.) institution. The Ministry of Health informed that on 17 September 2014 a meeting of the Ministry of Health had evaluated the existing situation in organising the provision of personal health care, social and other services to unsober persons. The representatives of all the attending institutions,

including the Police Department, the Ministry of Social Security and Labour and the Association of Local Authorities, had agreed on the urgency of the problem, but none of them had assumed the responsibility to organise additional services and their financing with the budget allocations for the institutions. In the Ministry's opinion, as Lithuania had some successful state-funded providers of the general and short-term social care and temporary accommodation services, for example, Sala, a branch of the Vilnius Emergency Lodging House, the long-term experience of which suggested that the Association of Local Authorities could take an initiative to promote the proper organisation and funding of temporary accommodation services for unsober individuals.

IMPRISONMENT INSTITUTIONS

In 2016, the Seimas Ombudsmen assessed the human rights situation at Alytus Correction House (Report No. 2016/1-55 of 21 July 2016). The inspection was carried out in four thematic areas: (1) detention conditions; (2) security; (3) the right of access of information and of submitting appeals; and (4) health care.

The following problems and most common violations of human rights have been identified:

1. Concerning the detention conditions. Most of the premises are not adapted to the movement of persons with disabilities; there are no shelves or rails installed at a lower height, or sufficient space for the free movement of wheelchairs; wheelchairs and other means compensating physical disabilities are in short supply; the number of seats in the courtyard is inadequate, and in the library the availability of audiobooks and other alternative electronic measures for access to information and possibilities of distance learning are insufficient; proper cleanliness and ventilation are

not ensured in the institution's sanitary facilities, and their equipment is either dysfunctional or damaged; personal privacy in using the toilet is not ensured; there is no guarantee of the possibility for drying one's clothing and footwear in a separate permanently open drier room; there is a shortage of clothes racks and tables, and the soft supplies provided are of poor quality.

2. Concerning the ensuring of security. Cell-type premises are in short supply, which forces to keep the convicts in a temporary detention cell for several days that is not adapted for long-term detention, and the fact of staying on this cell is not recorded; the number of the supervising officers is not sufficient to ensure security; and the minutes of the convicts' distribution commission are not informative.

3. Concerning the implementation of the right of access to information and submission of appeals. The right of access to information on the procedure and conditions for serving the sentence, persons' rights and duties and submission of proposals, requests (applications), petitions and complaints is not ensured; the employees of the unit for disabled convicts are not trained to deal with individuals with special needs.

4. Concerning the provision of health care. The persons' medical histories lack entries and signatures confirming the consent with the health check-up, examination by a doctor and prescribed treatment, the number of jobs in the health care service is non-compliant with the number of jobs set out in relevant standards; and there was no license and permit/hygiene passport for the provisions of services of a family doctor and a psychiatrist, and the internal medicine doctor was delivering services not provided for in the license.

On completing the inspection at the imprisonment institution, 14 recommendations were provided to the heads of the Prison Department

under the Ministry of Justice of the Republic of Lithuania and Alytus Correction House. The majority of the recommendations have been implemented (12) or are being implemented (2).

The Prison Department has informed that in 2016 the number of officers' positions at Alytus Correction House was increased from 187 to 206, but attempts to fill in all vacant positions faced difficulties: as of 1 December 2016, only 169 out of 206 positions had been filled in. With a view to increasing the attractiveness of the officers' jobs, the position of a supervisor classified as category 3 of level C with the lowest salary was eliminated (the institution had 61 such positions), and the position of a senior supervisor in category 4 of level C was introduced (64 such positions). Also a project for the conversion of the 600-bed dormitory into a residential building with cells was prepared (the works with the budget of EUR 100 000 are to start in 2017); and the heads of the places of detention were requested to take the Seimas Ombudsmen's recommendations into consideration and provide conditions for convicts who were insolvent due to actions beyond their control to submit proposals, requests, petitions or complaints to national and municipal authorities, non-governmental organisations or international institutions.

The Alytus Correction House Administration has drawn up a plan of measures for implementing the Seimas Ombudsmen's recommendations, which have been implemented: a leisure room has been installed in the unit of disabled convicts, and a pergola with a table and benches have been built in the courtyard; the stairclimbers available on the stairway are in use, rails have been installed in the hallways and a supply of wheelchairs, walkers and handrails for the disabled has been received; the damaged and dysfunctional fixtures of the sanitary facilities have been replaced and

partitions ensuring privacy have been put up; the showers have been outfitted with handrails, shelves for personal toiletries and anti-slip rubber mats; the rooms have been equipped with clothes rails, bedside tables and new soft supplies of appropriate quality; the possibility has been provided to dry one's clothes in a separate and permanently open drier room; an additional information board has been put up; the possibility has been provided to use a computer with internet access (for the search for legal acts), and a supply of books has been received; an agreement has been concluded with the Alytus unit of the Vilnius County Sign Language Interpreters Centre on the sign language interpreter services, the organisation of sign language courses at the Correction House; and the employees and squad masters have been trained to deal with persons with special needs (training and interviews conducted). Also measures have been taken to ensure that convicts are held in the institution's temporary detention facilities only for a short time while no other possibilities exist to solve the accommodation issue in a different way, and that the detention at these facilities is recorded. The minutes of the convicts' distribution commission specify the possible types of accommodation and, where appropriate, other information (the psychologists opinion, etc.). The medical histories of the convicted persons contain entries and signatures confirming consent with the health check-up, examination by a doctor and appointed treatment.

Two recommendations have not been implemented yet: due to small and uncompetitive salaries it is difficult to attract health care professionals and fill in the vacancies in the Health Care Service as well as find appropriate solutions for the structure and license issues. All efforts are being made to search for specialists, and medical doctors' training establishments are approached. The

position of the head of the Health Care Service has been filled in successfully.

A dialogue is continuing on the questions of the delivery of health care services at imprisonment institutions and the implementation of the provided recommendations is pursued.

PLACES OF DETENTION FOR FOREIGNERS

In 2016, the Seimas Ombudsmen assessed the human rights situation at 3 (three) places of detention for foreigners: the Raigardas Border Inspection Post of Druskininkai Frontier Station, Kabeliai Frontier Station and Aleksandras Barauskas Frontier Station of Varėna Frontier District of the State Border Guard Service under the Ministry of the Interior of the Republic of Lithuania (Report No. 2016/1-24 of 11 May 2016).

The following main problems and most common violations of human rights have been identified:

1. Concerning registration of delivered persons. The registers of delivered persons not always specify whether a person was placed in a detention facility and how much time a detained individual spent there.
2. Concerning the conditions in the detention facilities. The facilities are not adapted for detention of more than five hours; the requirement of the rules on the use of facilities regarding the provision of soft supplies fails to meet the international standards (stating that detained persons should get a mattress and a blanket at night-time); and appropriate artificial lighting is not ensured. Also a shortage of technical equipment for the surveillance of detained persons has been detected.
3. Concerning the adaptation of premises to persons with disabilities. The premises (including their sanitary facilities) are not adapted to

persons with disabilities, and no conditions exist for access to the border stations without additional obstacles (no ramps installed at the entrances).

4. Concerning the ensuring of cleanliness. Cleanliness is not ensured in the facilities' sanitary rooms, the plumbing fixtures are in poor condition, and there is no constant observation and destruction of rodents and arthropods.

On completing the inspections at the border stations, the State Border Guard Service received 10 recommendations (of which three ones dealt with the improvement of the legal framework). Of this number, eight recommendations have been implemented, and information on the implementation of the other two recommendations is awaited. The Ministry of Health received one recommendations which has been implemented.

The State Border Guard Service has informed that, with the additional funds allocated for 2017, works will be performed at the border stations to adapt them to the needs of persons with disabilities (ramps, entrance doors to the premises, and detention and personal hygiene facilities). If no additional funds are assigned, these works will be carried out to the minimum extent with the allocations made to the border districts. The requirement of the above-mentioned rules has been amended to stipulate that persons to be held in temporary detention facilities for more than 24 hours or at night-time should be provided with soft supplies; the border stations of the Varėna Border District have received soft supplies (mattresses, pillows, bed sheets, blankets, etc.), and the question of the installation of additional sleeping places in the detention facilities is being resolved. The lacking technical equipment for the surveillance of detained persons and the artificial lighting compliant with the statutory requirements are to be installed in Q1 2017.

Officers of the border stations have received additional instructions always to record the fact of holding a person delivered to a border station in the detention facility and the length of his or her stay there. They have also been obligated to specify the exact time, without rounding it up or down. The border stations and other structural units of the Varėna Border District have been supplied with first aid kits containing appropriate items; the sanitary rooms of the detention facilities have been provided with personal hygiene items (soap, tissues, tissue towels, etc.) and the plumbing fixtures have been restored to good and functional condition. Further information is awaited about the recommendation that the first aid facilities / lighting / cells should be supervised during inspections, and the recommendation that a possibility should be discussed to improve the legal framework on the supply of administrative and temporary detention facilities with personal hygiene items and other necessary articles.

Also a recommendation has been issued to the Ministry of Health to consider the possibility of clarifying the existing legal framework by supplementing the list of facilities in which the constant observation and destruction of rodents and arthropods should be organised and carried out, and including in this list the border districts, border stations and border inspection posts of the State Border Guard Service as well as the Refugees Reception Centre. The Ministry of Health has implemented the Seimas Ombudsmen's recommendation to supplement the list of facilities wherein the constant observation and destruction of rodents and arthropods should be organised and carried out as provided for in the Procedure for the compulsory preventive elimination of the harmful effects of the environment (disinfection, disinsectisation and destruction of rats), by including in this list also the Refugees

Reception Centre, border inspection posts and the temporary detention and asylum seekers facilities available at the structural units of the State Border Guard Service (para. 14 to 16 of Annex 1 to the Procedure).

MENTAL INSTITUTIONS

With a view to finding out how the preliminary comments provided by the European Committee for the Prevention of Torture are complied with, a visit was paid to the Rokiškis mental institution.

Members of the European Committee for the Prevention of Torture visited Rokiškis Mental Hospital in September 2016. The Committee provided comments on the patients' complaints about the use of rough language by the nursing staff, the poor food quality and small rations, as well as about the privacy for female patients, the limited possibilities for patients in Unit B to use the courtyard, the presence of patients in lockable premises for 23 hours during the 24-hour period, the insufficient participation of patients in the rehabilitation activities, the overcrowded wards, the use of restraints in the presence of other patients, the participation of the a security guard in this process and the absence of a separate log for recording information about the use of restraints.

1. Concerning the patients' complaints about the use of rough language by the nursing staff. It has been found that in 2016 the hospital's administration received no complaints of this kind, and has constantly reminded the personnel of the need to strictly observe the internal rules of procedure approved by the institution and the requirements of professional ethics. Also plans are developed for conducting patient surveys. In 2015–2016, the employees improved their qualification,

participated in training which analysed the features of stress and fatigue at work, cases of actions of the medical staff in emergencies, methods of controlling patient's verbal aggression, the reasons of violence and aggression in mental nursing and the tactics of employee actions, and discussed the specifics of dealing with mentally disabled aggressive patients and ways to identify the patients' manipulative behaviours.

2. Concerning the comments relating to the application of restraints. It has been established that measures have been taken to ensure that patients are not restrained in the presence of other patients (the restraint bed has been moved to a single ward or patients are asked to leave the ward). A security guard is involved only where the number of the personnel in a unit is not sufficient. The restraint procedure is headed only by the institution's health care professional who has not only received training in the use of restraints but also improves his qualification in this sphere regularly. The contract with the security guard company specifies that security guards must "know how to behave with patients". A staff meeting has adopted a decision to register the use of restraints in a separate log.

3. Concerning the patients' complaints about the poor food quality and small rations. It has been found that the hospital's possibilities to substantially improve the quantity and quality of food supplied to the patients are limited, as in the process of organising patients' meals and payment for them the institution cannot ignore the established hygiene, one patient daily energy and nutrients standards or differentiate the food rations according to the patients' individual needs. The hospital has appointed separate persons to place patients catering orders and must control compliance of the product weight, yield and nutritional and energy value with the values

specified in the technological cards of dishes. The administration of the institution will enhance measures to implement these controls.

4. Concerning the lack of privacy for female patients. In the special observation unit for women and children, the patients are not divided into isolated sectors, leading to the absence of differentiation of their right to privacy in the wards with account of the observation conditions defined by the court. Privacy in the wards is not ensured: the ward doors have windows in them and all people passing by, i.e. not only the personnel but also other patients can watch women through them unrestrictedly. However, hanging up curtains, for example, would render the guarantee of the patients' security more difficult. No violations of privacy when using the sanitary facilities have been identified: the windows in the doors of the sanitary facilities are covered, and the doors can be locked safely. With a view to improving the women's treatment conditions at the institution and also ensure the rights provided for them in the laws, the hospital administration has applied for funds for the construction of a new unit.

5. Concerning the overcrowded wards (with four or five patients). It has been established that the wards with five beds are currently under repair in order to ensure the requirements of the hygiene standard.

6. Concerning the possibility to use the courtyard and the comments that patients spend most of their time in lockable wards. It has been found that in Unit B the treatment is conducted under

the conditions of strict supervision and the patients get special attention for the purpose of avoiding escapes and/or protecting them and other persons from other unpredictable actions. Therefore these patients are walked outside in small groups (of not more than 10 persons) and only when escorted by a nurse and a security guard (one patient must be escorted by one security guard and two patients by two security guards). With a view to ensuring a longer daily stay of the Unit B patients outdoors, the number of security guards should be enlarged, but the institution has no additional resources for that at the moment. The long time that the patients spend in the wards is also related to the shortage of the personnel. The hospital director has promised to review the employees' work schedules and functions again in order to solve these questions.

7. Concerning the patients' participation in psychosocial rehabilitation activities. Psychosocial rehabilitation activities are constantly organised for the patients, except those in the strict and enhanced observation units. The employees devote sufficient attention to the engagement of the patients in these activities, and constantly urge them to do that. The psychologist who participated in the visit at the institution has noted, however, that the scope of the psychological services is inadequate, and that the psychosocial rehabilitation and other psychological or social services should be provided to all patients, including those in the strict and enhanced observation units.

Follow-Up Inspections

The follow-up on the implementation of recommendations issued to the responsible authorities is a very important aspect of the national prevention of torture, which allows identifying the specific actions taken by an institution to implement those recommendations and whether they were implemented successfully.

With a view to implementing the provided recommendations, the responsible authorities must take appropriate actions, while the Seimas Ombudsmen supervise the implementation of these recommendations. During this process the institution conducting the prevention of torture monitors the information on measures taken by the responsible authorities according to recommendations provided to them, and in different ways also actively keeps promoting the appropriate implementation of its recommendations.

Follow-up inspections are one of the most effective measures to control the implementation of recommendations. These inspections are aimed at finding out the results of implementation of the Seimas Ombudsmen's recommendations and evaluating the information provided by an institution on site.

In 2016, the Seimas Ombudsmen conducted a total of 17 (seventeen) follow-up inspections at different places of detention. Follow-up visits were held to 10 (ten) adult social care institutions, 3 (three) to imprisonment institutions, 2 (two) to police stations and one to each of a mental hospital and a foreigners' detention facility. These inspections evaluated how the heads of the institutions had implemented 231 recommendations provided to them. Of this number, 140 and 41

recommendations were implemented in full and in part respectfully, while 50 ones were not implemented at all.

MENTAL INSTITUTION

During the reporting period, one follow-up inspection was carried out at the Mental Clinic (hereinafter referred to as "the Clinic") of the public establishment Republican Šiauliai Hospital. During the 2014 visit at the Clinic, 14 recommendations had been issued. To implement these recommendations, the Director of Šiauliai Hospital set up a working group which analysed the Seimas Ombudsmen's conclusions and drew up a plan for the implementation of those recommendations that was submitted to the Seimas Ombudsmen's Office. It is noteworthy that some of the Seimas Ombudsmen's recommendations were implemented in full or in part, and a dialogue was continuing on those ones that were left unimplemented.

The follow-up visit has found that of the 14 recommendations made by the Seimas Ombudsmen nearly all of them have been implemented: 12 recommendations have been fully implemented, and two ones have been implemented in part.

The follow-up visit has established that the human rights situation at the Mental Clinic of the public establishment Republican Šiauliai Hospital has improved, as the following recommendations have been implemented: forcibly hospitalised persons are, against signature, informed of a court hearing that will decide the issue of their forced

hospitalisation and treatment and of their right to participate in the hearing; cases of patients' restraint are recorded in a special log, specifying various facts that help to identify possible violations of human rights; a separate room has been installed for meetings with the close family and other persons; if necessary, patients of the institution are immediately provided with a translator's services; the Clinic carries out analysis of questions raised in written inquiries submitted by patients; patients are regularly supplied with information on sexual and reproductive health, family planning and side effects of contraceptives; patients undergoing treatment voluntarily have the possibility to submit an application for the refusal of treatment or the use of alternative treatment methods, etc.; patients are provided with information on the prescribed treatment, administered medications, effectiveness of treatment, etc.; patients, except for the exemptions provided for in legislation, can have unrestricted access to the medical records and their extracts; patients are supplied with various personal hygiene items, such as bathing and tooth brushing items, toothbrushes, combs, etc.; privacy is ensured in the hygiene facilities; employees show constant attempts to take the patients' preferences regarding meals into consideration; single-person wards have been outfitted; all patients have the opportunity to go for a daily walk outdoors; and the smoking room has been removed.

However, the recommendations of the Seimas Ombudsmen concerning the ensuring of the minimum living space (7 m²) per bed (patient) in a ward and the maximum number of four beds per ward, as well as the recommendation for organising training on relevant topics have not been implemented: there was no training that would analyse cases of the use of restraints for patients, the provisions of the United Nations Convention on the Rights of Persons with Disabilities or their implementation problems.

The answer will be provided by 28 February. Supplying the information on the recommendations made during the follow-up inspection, the institution has informed that plans for renovation of the premises have been drawn up for the Clinic, and investment projects are being coordinated for reducing the number of beds to four per ward. There are also plans to install surveillance cameras in all common spaces (hallways).

IMPRISONMENT INSTITUTIONS

During the reporting period, three follow-up visits were held to imprisonment institutions, including Lukiškės Remand Prison – Closed Prison (hereinafter referred to as "Lukiškės RPCP"), Kaunas Juvenile Remand Prison – Correction House (hereinafter referred to as "Kaunas JRPCH) and Panevėžys Correction House (hereinafter referred to as "Panevėžys CH") (Report No. 2015/1-99). On completing the inspections at the imprisonment institutions, 46 recommendations in total were issued to the heads of the Prison Department under the Ministry of Justice of the Republic of Lithuania and the imprisonment institutions subject to inspection: seven to the Prison Department, 16 to Kaunas JRPCH, one to Lukiškės RPCP and 22 to Panevėžys CH. The information supplied by the institutions shows that 44 recommendations have been implemented, while two ones have been left unimplemented.

The follow-up visit has found that of the 46 recommendations provided by the Seimas Ombudsmen the majority has been implemented: 26 implemented in full, 12 implemented in part, and 8 not implemented.

The follow-up inspection at Panevėžys CH has established that of the 22 recommendations made 11 ones have been implemented, eight

recommendations have been partially implemented and three ones have been left unimplemented. Supplying the information on the implementation of the recommendations issued during the follow-up inspection, Panevėžys CH has informed that the institution has agreed with almost all of them and taken active steps to eliminate the existing shortcomings. The institution has expressed its disagreement with one recommendation relating to the provision of personal health care services at the institution during night-time (the Seimas Ombudsman had doubts about whether access to personal health care services was ensured at night). Therefore the Seimas Ombudsmen will continue their cooperation with the head of Panevėžys CH and representatives of the Prison Department for the purpose of improving the convicts' situation at Panevėžys CH.

The follow-up inspection at Lukiškės RPCP has found that one recommendation issued has been implemented in part. Providing the on the planned actions, Lukiškės RPCP has indicated that the recommendation concerning the reduction of the number of beds in the cells by removing non-used bunks will be complied with in full within a year.

The follow-up inspection at Kaunas JRPCP has established that of the 16 recommendations issued, 12 have been implemented in full, two have been implemented in part and two have not been implemented at all. The follow-up visit has stated that two recommendations have remained unimplemented: one for ensuring that the number of positions in the Health Care Service complies with the number of employee positions defined in legal acts and that all positions approved at this Service are filled in, and the other one for ensuring that the rubber batons worn by the security guards are not openly displayed. Supplying the information about the results of the follow-up inspection, Kaunas JRPCP has noted that active

steps have been taken to eliminate the shortcomings identified during the follow-up inspection.

The follow-up visits at the above imprisonment institutions have also assessed how the institutions have complied with the recommendation issued by the Seimas Ombudsman to the Police Department. The follow-up visits to the imprisonment institutions have stated that of the seven recommendations provided to the Prison Department the imprisonment institutions have implemented three recommendations in full, one recommendation has been implemented in part and three ones have not been implemented yet. It is noteworthy that some of the recommendations issued to the Police Department have not been implemented for the reason that the legal framework needs to be amended and additional funds for renovation of the premises should be found. It should be stressed that the Prison Department has undertaken to improve the legal framework concerning placement in a disciplinary remand cell, a punishment applied to minors. In 2016-2017, the Prison Department has also provided for state budget appropriations for the installation of ramps and the adaptation of the residential premises of the imprisonment institutions for the disabled, and has foreseen to initiate amendments to the Penal Enforcement Code concerning the establishment of a procedure for payment of expenses for travel to long-term meetings when both spouses serve their imprisonment sentences.

POLICE INSTITUTIONS

During the reporting period, follow-up visits were held at two police institutions: the custody and temporary detention facilities of the Panevėžys County Police Headquarters (hereinafter referred to as "the Panevėžys CPH") and the temporary detention facility of the Panevėžys City Police

Station (hereinafter referred to as “the Panevėžys PS”). These places of detention had been inspected in August-September 2014, and had been given 16 recommendations, of which 12 had been concerned with the Panevėžys CPH premises and four with the Panevėžys PS premises.

During the 2014 inspections, most of the recommendations dealt with the ensuring of the established minimum living space (5 m²) per person, as well as with the adaptation of the premises and entrances for people with disabilities, the ensuring of cleanliness, possibilities for detainees to dry their laundry and privacy by installing appropriate partitions of the sanitary facilities, the proper supply of information to persons on their rights and duties, and the appropriate provision of information relevant for detainees.

When supplying the information on the implementation of the recommendations, senior management of the Police Stations has indicated that they have agreed with 13 recommendations issued by the Seimas Ombudsman, and has promised to take measures to ensure that the identified shortcomings are eliminated. Cooperation has continued on three recommendations that have not been approved.

The follow-up visit has found that of the 16 recommendations issued only five ones have been implemented in full, one recommendation has been complied with in part, while 10 recommendations have not been implemented. When providing the information on the implementation of the recommendations given during the follow-up inspection, senior management of the Police Stations has indicated that nearly all the recommendations have been implemented and that there is one recommendation not implemented which relates to ensuring of conditions for detainees to dry their laundry. Cooperation on the implementation of

this recommendation will be carried on not only with senior management of the police stations but also with other institutions concerned.

PLACES OF DETENTION FOR FOREIGNERS

During the reporting period, also one follow-up inspection was conducted at a place of detention for foreigners, i.e. the Refugees Reception Centre (hereinafter referred to as “RRC” or “the Centre”). The follow-up inspection was performed with the aim of establishing whether the recommendations issued during the previous inspections had been implemented, and considering the fact that Lithuania had an obligation for the European Union to accept more than a thousand persons from military conflict regions and accommodate them at the RRC. During the 2014 visit at the RRC, eight recommendations had been provided. Supplying the information on the implementation of recommendations, the Centre indicated that all of them had been complied with or they were to be implemented by the end of 2016 at the latest.

The follow-up visit has found that, of the eight recommendations issued, five ones were implemented in full and three ones in part. Therefore the Centre has been urged again to take steps to ensure that all recommendations are implemented properly. According to the latest information from the administration of the Centre, all recommendations issued during the follow-up inspection were implemented shortly after that inspection (the RRC has also added evidence supporting this statement).

SOCIAL CARE INSTITUTIONS

During the reporting period, follow-up inspections were carried out at 10 adult social care

institutions which received a total of 147 recommendations: Vilijampolė Social Care Home (13 recommendations), public establishment Old People's Home Užusaliai (12), Kaunas Panemunė Old People's Home (11), Kėdainiai Social Care Home (18), Jonava Care Home (18), public establishment Globasta (21), public establishment Ežerėlis Care Home (seven), Čekiškė Social Care Home (14), Rumšiškės Old People's Home Auksinis amžius (15) and public establishment Amžiaus žiedas (18) (hereinafter jointly referred to as "care institutions" or "institutions"). The recommendations were provided to the Social Services and Care Department under the Ministry Social Security and Labour for this Department to take measures within its competence to ensure that the shortcomings found at the care institutions were eliminated. Providing the information on compliance with the recommendations to solve the problems identified at the care institutions, the Social Services and Care Department has noted that all ten specified institutions will be included in the list of higher-risk institutions and the plan of care institutions that will be subject to evaluation based on the relevance of the information in the Report (No. 2015/1-74) and, if necessary, appropriate enforcement measures will be taken.

The follow-up visits at the care institutions have found that, of the total of 147 recommendations, the care institutions have fully implemented 92 of them, 23 have been implemented in part, while 32 recommendations have remained unimplemented.

In assessing the information obtained during the follow-up inspection on the unimplemented recommendations, it should be stated that these recommendations were mostly concerned with: making the residents aware of their rights and duties in a proper way, but the residents continue

to be informed of the internal rules of procedure only formally, while the rights and duties are not explained to them in a language understandable to them (in five care homes); the approval of the number of positions larger than that provided for in the standards, with account of the needs of the recipients of the service of a specific care institution, for example, the availability of the social worker's services illness or vacation (in three care institutions); the absence of the emergency call system (in three care institutions); the ensuring of the residents' personal hygiene, i.e. the frequency of the residents' bathing, change of their underwear and bedding (in three care institutions); the knocking by employees before entering the residents' rooms (in two care institutions); the participation of employees in training programmes related to the rights of the disabled and the elderly (in two care institutions); the inadequate promotion of the residents' independence (in two care institutions); and the provision of opportunities to enable persons with reduced mobility to observe the environment through the window (in two care institutions). The other unimplemented recommendations were more of an individual nature and intended for separate care homes. It is noteworthy that, on establishing in a few cases that a care institution had failed to comply with certain recommendations, the appropriate founder of the care institutions was approached to ensure that they also took steps to achieve the quickest possible implementation of the recommendations issued by the Seimas Ombudsmen.

According to the information supplied by the institutions after the follow-up inspection, almost all recommendations provided repeatedly were implemented immediately after the follow-up inspections or the institutions were obligated to comply with them on obtaining the required funds.

Additional Activities

On 9 March 2016, Seimas Ombudsman Raimundas Šn 9 March 2016, Seimas Ombudsman Raimundas Sinstitutions after the follow-up inspection, almost all recommendations provided repeatedly were implemented immediately after the follow-up inspections or the institutions were obligaerepresentatives of the Seimas Ombudsmen's Office also visited several social care institutions for older people in Lithuania.

On 16 June 2016, Augustinas Normantas, head of the Seimas Ombudsmen's Office, met with Tatyana Teplova and expert Chloe Lelievre, representatives of the mission of the Organisation for Economic Co-operation and Development (OECD) in Lithuania. The meeting with Mr. Augustinas Normantas dealt with the themes of ensuring the rule of law and the effective activities of institutions administering justice in Lithuania.

On 5 September 2016, at the invitation of Seimas Ombudsman Augustinas Normantas, the European Council Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, shortly referred to as the CPT, presented its preliminary conclusions at the Seimas Ombudsmen's Office concerning the human rights situation at the places of detention in Lithuania.

At a meeting with Ted Janis and Giedra Gurevičiūtė-Demereckienė, representatives of the US Embassy, held on 14 September 2016, the Seimas Ombudsman disclosed relevant issues complained about to the Seimas Ombudsmen by Lithuanian residents and presented human rights problems arising at places of detention. The meeting also discussed questions of cooperation

with the US Embassy as the US State Department was preparing a report on the human rights situation in the country.

On 6 December 2016, Seimas Ombudsmen Augustinas Normantas and Raimondas Šukys met with Nils Muižnieks, Commissioner for Human Rights of the Council of Europe, to discuss gender equality, the rights of persons with disabilities, the rights of children, violence at home as well as the problems of the care home system and their abundance in Lithuania. The Commissioner for Human Rights also showed an interest in the activities of the Seimas Ombudsmen and other human rights mechanisms operating in Lithuania.

The Seimas Ombudsmen's Office has been a member of the International Ombudsman Institute since August 1996. In 2016, representatives of the Seimas Ombudsmen's Office participated in several important events of this Institute. On 26-27 April 2016, Augustinas Normantas, Seimas Ombudsman and Head of the Office, and Seimas Ombudsman Raimondas Šukys took part in the European regional conference "Human Rights in Europe: Challenges for Ombudsmen" held in Barcelona by the International Ombudsman Institute. The conference discussed the issues of ensuring privacy and personal data security, the approach towards asylum seekers and their identification with terrorists, as well as the asylum policy in Europe, the possible measures to combat the emerging xenophobia in Europe and the ombudsmen's role in solving the refugee crisis on the European continent.

At the conference "Evolution of Ombudsmanship" held on 13-19 November 2016 in Bangkok,

Thailand, at the invitation of the International Ombudsman Institute, the Chief Public Relations Counsellor of the Seimas Ombudsmen's Office delivered a report "The Use of Media to Promote Ombudsmen's Work in Protecting Human Rights", and together with the Seimas Ombudsman and Head of Office participated in the discussion "Ombudsman Work Resulting from Multiple Mandates: Challenges and Opportunities" organised by the Association for the Prevention of Torture (APT).

In 2016, the Seimas Ombudsmen's Office also took an active part in the work of the International Ombudsman Institute by supplying information on the activities of the Office, replying to the questions presented in the sent questionnaires and voting in the election of the president and board members of the European Region of the International Ombudsman Institute.

On 21-23 June 2016, officials of the prevention of torture from 16 European countries gathered in Vilnius for an international workshop on the

occasion of the 10th anniversary of the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. The workshop "Monitoring of Psychiatric Facilities" was organised by the Seimas Ombudsmen's Office, the International Ombudsman Institute and the Association for the Prevention of Torture.

Psychiatrists from Great Britain and Austria working in the sphere of human rights and experts from the United Nations Committee against Torture, the Council of Europe and the International Ombudsman Institute taught officers for prevention of torture in Vilnius how to talk to persons with mental disabilities, what to pay attention to during visits at mental institutions and problems faced by persons placed at such institutions. The workshop participants also visited the Rokiškis Psychiatric Hospital.

The workshop was aimed at identifying common problems most often encountered by officers for prevention of torture and enhancing the knowledge on potential risks related to the monitoring of mental institutions.

Conclusions

The previous year reported posed not only challenges to the Seimas Ombudsmen's Office but offered multiple opportunities. One of which the training organised in Lithuania by International Ombudsman Institute which gave us possibilities to get a more comprehensive understanding of challenges that may arise during the inspections conducted in mental institutions.

At the same time, the discussion between representatives of NPM from different countries organised by the Council of Europe served as a forum for various ideas and exchange of views as to how the performance of NPM shall be improved. Furthermore, a meeting with the representatives of the Committee on Torture of the Council of Europe in the premises of the Seimas Ombudsmen's Office

with the aim of presenting initial findings after their visit to several institutions in Lithuania was of great importance. Because of this, we could not only facilitate dialogue with different stakeholders for accommodating greater interest among them in the outcomes presented by delegates but also for creating opportunities to learn more about the idea of the preventive mechanism.

Finally, after the ratification of Optional protocol, we could get to the bottom of systemic problems which were not apparent during an investigation of individual complaints. This empowered us to seek for resolutions to the problems by initiating different meetings with state and municipal authorities, other stakeholders, and proposing amendments to the legislation.