Mental Disability
Advocacy Centre – May 2017

STRAIGHTJACKETS AND SECLUSION

AN INVESTIGATION INTO ABUSE AND NEGLECT OF CHILDREN AND ADULTS WITH DISABILITIES IN HUNGARY

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Cover: Boy between 11 and 13 years old on one of the men's wards. The straightjacket was fashioned by tying the sleeves behind his back. He also had injuries and swelling to his face, bruising on his feet and ankles and was in distress. Taken on 18 April 2017. © MDAC.

TAKEN ON 18 APRIL 2017. © MDAC.

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TAKEN ON 18 APRIL 2017. © MDAC.

A young woman on Female Ward A behind a wooden fence.

EXECUTIVE SUMMARY

Topház Speciális Otthon ("Topház Special Home") is a 220-bedded residential institution for children and adults with disabilities in the town of Göd, approximately 30km from the Hungarian capital, Budapest. When MDAC visited on 18 April 2017, a black flag was flying outside the locked gates, alongside the Hungarian national flag. Inside the institution, we entered one bare shared bedroom and noticed an empty bed which had a small plant in a pot rested on top. The week before our visit, we were told that a male resident of the institution had sadly passed away, and this was how the institution marked his passing.

This report, based primarily on a visit to Topház by an MDAC team on 18 April 2017, sets out findings from that day. They indicate serious abuse and neglect of adults and children with intellectual, cognitive, developmental, multiple and profound disabilities who are living there. The MDAC team saw incidences of torture or ill-treatment against residents: people with multiple disabilities inside metal cage beds, seclusion and physical restraints behind locked doors, a young boy in a makeshift straightjacket, untreated open wounds, and indications of malnutrition.

MDAC and partners were denied permission to visit on 15 November 2016, when a team arrived to conduct monitoring. When the team visited on 18 April 2017, it was clear why permission had been previously denied. The closed and secretive nature of this institution has created the conditions for impunity to thrive, and abuse and neglect to be perpetrated.

The conditions, abusive practices and evidence of violence seen in this institution are the result of systemic failings in law, policy, and regulation and a lack of effective and independent monitoring. People with disabilities have the right to support and services to live independently and be included in their community. Instead of providing these supports and services, the 220 people in Topház, like tens of thousands of other people with disabilities in institutions in Hungary, continue to be warehoused away from the public gaze. Despite their names, institutions such as Topház Special Home are not homes.

The Hungarian Government has invested significant public funds building and renovating institutions such as Topház. Yet, MDAC found that the institution does not meet the basic needs of its residents in terms of safety, food, health, education and child development. Many of the physical, cognitive and other impairments of residents are potentially consistent with harm caused by long-term institutionalisation and exposure to harsh conditions and treatment.

These basic needs must be met. Once this is done, the Hungarian Government should direct their policies and funds to community investments, so that no people with disabilities live in institutions, isolated and segregated from the community.

This report contains information collected during visits to Topház between 15 February 2017 and 18 April 2017 by an MDAC team with expertise in law, human rights, disability rights, special education, cognitive science and child protection. Due to indications of serious abuse and ill-treatment against several residents, MDAC was under an obligation to alert the police of its findings. MDAC will monitor the Hungarian authorities' actions going forward.

The content of this report has been edited to protect the identities and dignity of residents, in compliance with relevant Hungarian and international law.

MDAC thanks numerous professionals, lawyers, specialists and human rights defenders who advised in the preparation of this report. MDAC works within a network of people and civil society organisations who are committed to ending isolation, segregation and abuse against people with disabilities worldwide.

CONCLUSIONS AND RECOMMENDATIONS

Hungary has human rights obligations under United Nations and Council of Europe treaties it has ratified. It has accepted obligations to protect, respect, promote and fulfil the human rights of everyone in its territory. Based on the findings set out in this report, MDAC urges the Government to take urgent steps, including:

1. Immediately ensure medical, psychological, and psychiatric evaluations and needs assessment for all residents of Topház and provide for their basic and emergency physical, psychological and psychiatric needs without delay.
2. Take immediate steps to close Topház and other residential institutions where people with disabilities are detained, ensuring that residents are repatriated to the community.
3. In the interim, open all social care and other facilities for persons with disabilities across the country to independent inspection by civil society and the international community.
4. Publish the accounts of the Topház institution and clarify how much funding has been spent, on what items, including financing from the European Union.
5. Establish a reparations fund and reparations agency for victims of human rights violations in Topház and elsewhere who have suffered torture, cruel, inhuman or degrading treatment or punishment. Identify victims and ensure that restitution, compensation, rehabilitation and satisfaction are provided without delay, in compliance with UN General Assembly Resolution 60/147 of 16 December 2005 on “Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law”.
6. Adopt a legislative prohibition on the placement of people with disabilities into institutions on the basis of an actual or perceived disability, and enshrine the right to independent living in the community for all persons with disabilities in law, including the right to access support and services necessary for independent living, habilitation and rehabilitation, and personal assistance.
7. Ensure the police undertake investigations into all possible allegations in this report that constitute crimes under Hungarian law. The Government should ensure those responsible for this abuse and neglect at all levels are identified and held to account.
8. Amend the criminal law to establish an offence of torture on the basis of disability, clearly setting out that treatment applied discriminatorily on the basis of actual or perceived disability is prohibited.
9. Ensure that human rights monitoring of all residential institutions for persons with disabilities is conducted with the collaboration of the Ombudsman,

people with disabilities and their representative organisations, and representatives of national and international civil society.

10. Suspend all government programmes that provide financing for the institutionalisation of persons with disabilities. Reallocate such funds to invest in genuine community-based services.

During these visits, the MDAC team also became aware that Topház and other residential institutions for persons with disabilities have received financing from European Structural and Investment Funds administered by the Hungarian Government.
In this light, we recommend that the European Commission, specifically the European Anti-Fraud Office (OLAF), immediately open an audit and investigation into breach of fundamental rights in the use of European funding in Topház and other institutions for persons with disabilities. This should be in line with the decision issued by the European Ombudsman in her own-initiative inquiry concerning EU cohesion policy and respect for fundamental rights.[1] The European Commission should consider whether the allegations breach the Charter of Fundamental Rights of the European Union and the option of opening infringement proceedings under EU law.

LIST OF ACRONYMS

CAT:	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, a UN treaty, ratified by Hungary in 1987
CEDAW:	Convention on the Elimination of all Forms of Discrimination Against Women, a UN treaty, ratified by Hungary in 1980
CERD:	International Convention on the Elimination of All Forms of Racial Discrimination, a UN treaty, ratified by Hungary in 1967
COE:	Council of Europe, to which Hungary acceded in 1990
CRC:	Convention on the Rights of the Child, a UN treaty, ratified by Hungary in 1991
CRPD:	Convention on the Rights of Persons with Disabilities, a UN treaty, ratified by Hungary in 2007
ECHR:	Convention for the Protection of Human Rights and Fundamental Freedoms, better known as the European Convention on Human Rights, a Council of Europe treaty, ratified by Hungary in 1992
EU:	European Union, to which Hungary acceded in 2004
ICCPR:	International Covenant on Civil and Political Rights, a UN treaty, 1974
ICESCR:	International Covenant on Economic, Social and Cultural Rights, a UN treaty, ratified by Hungary in 1974
OP-CAT:	Optional Protocol to the Convention against Torture, Cruel and Other Cruel, Inhuman or Degrading Treatment or Punishment, a UN treaty, ratified by Hungary in 2012
SZGYF:	Szociális és Gyermekvédelmi Főigazgatóság (“Directorate-General for Social Care and Child Protection”), an agency under the Ministry of Human Capacities with responsibility for public social care institutions in Hungary
UN:	United Nations

1 European Ombudsman, Own-initiative inquiry, Case No. OI/8/2014/AN (Decision), 11 May 2015, available online at https://www.ombudsman.europa.eu/en/cases/decision.faces/en/59836/html.bookmark (accessed 29 April 2017).

TAKEN ON 15 NOVEMBER 2016. © MDAC.

Metal fencing surrounds the institution.

TAKEN ON 15 NOVEMBER 2016. © MDAC.

Front entrance to the institution.

TAKEN ON 18 APRIL 2017. © MDAC.

A outdoor terrace corridor enclosed with fencing on one ward.

TAKEN ON 18 APRIL 2017. © MDAC.

The bathroom on one ward.

TAKEN ON 18 APRIL 2017. © MDAC.

Much of the bedding and other furniture was damaged.

TAKEN ON 18 APRIL 2017.

A boy in a partially enclosed metal barred cage bed on the Children's Ward C. © MDAC.

1. INTRODUCTION

1.1. MDAC

The Mental Disability Advocacy Centre (MDAC) is an independent international non-governmental organisation, that uses the law to advance human rights of people with mental health issues and intellectual disabilities worldwide. It has consultative status with the United Nations Economic and Social Council (ECOSOC) and participatory status with the Council of Europe.

1.2. ROADMAP OF THE REPORT

This chapter sets out recommendations to the Hungarian government and the EU. It describes the human rights situation of residents in the Topház Speciális Otthon ("Topház Special Home") for children and adults with disabilities. Chapter 2 sets out findings of visits which have been conducted to the institution by a team from MDAC. It begins by providing the key findings and their analysis using the lens of international human rights law which are binding on Hungary. It then lists findings from visits to each of five locked wards in the institution. The Appendix sets out MDAC's attempts to visit the institution since May 2016, a history of visits undertaken by other agencies, and the methods that MDAC used to prepare this report.

1.3. DESCRIPTION OF TOPHÁZ

TOPHÁZ SPECIÁLIS OTTHON
Munkácsy Mihály utca 2
2131 Göd
Hungary
+36-27-532-275
http://www.pmik.hu/index.php/vintezmenyek/szocialis/84-szocialis-intezmenyek/136-tophaz-specialis-otthon

DATE OF VISIT: 18 April 2017
(supplemented by preliminary visits on 15, 17 and 27 February, 9 March 2017)

Topház Speciális Otthon ("Topház Special Home") is a large residential institution located on the outskirts of the town of Göd, approximately 30km from the capital Budapest. It is surrounded by fencing with access from the road through an electronic gate controlled by a security officer in a small outhouse.

According to its website, the institution was established on 1 November 1977 in a converted former castle to house 100 children with mental, motor and multiple impairments. In 1981, it was significantly expanded to house 300 residents, but this was reduced to 220 beds in 1986.

Today, the institution still has capacity for 220 residents and houses children and adults with a variety of intellectual, developmental, mobility and physical impairments, as well as people with multiple and profound disabilities and complex

care needs. The vast majority of residents are under guardianship of family members or public guardians. The institution is made up of five closed wards, each of which has a similar structure and space for approximately 40 residents in shared bedrooms: one ward for children; one for girls and women; two for boys and men; and another called the "Family Group" ("Család Csoport") which had a different layout. This latter ward is for residents who are mobile and who, according to staff, display "challenging behaviour".

In 2004, a ten-bedded "residential home" was constructed separately from the main building, but on the same grounds, envisaged for use by certain residents to develop independent living skills. The residential home was not visited by the team on this occasion.

The institution is managed by Pest County Council. Standards are controlled by the Directorate-General for Social Care and Child Protection (*"Szociális és Gyermekvédelmi Főigazgatóság",* SZGYF), which is a semi-autonomous agency associated with the Ministry for Human Capacities.

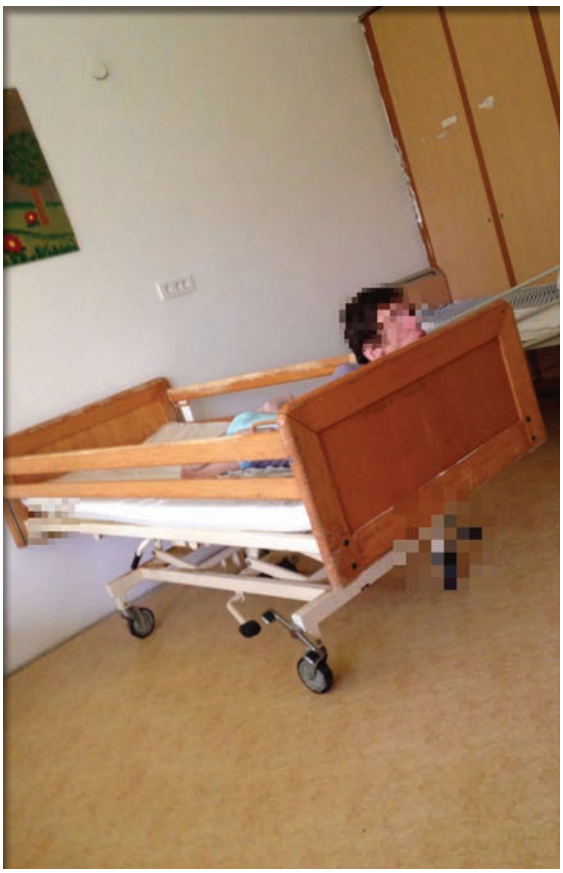
1.4. FINANCING

The detailed annual budgets of the institution - covering the period of 2012-2016 - are available on the website of SZGYF. The institution's annual budget was 542.7 million HUF (approximately 1.75 million EUR) in 2016. Less than 20% of this amount was covered by the fees paid by residents and the rest by the Ministry of Human Capacities. (Source: Közzétételi lista: Pest Megyei Topház Egyesített Szociális Intézmény - Éves költségvetések, available at http://pest.szgyf.gov.hu/index.php/kozerdeku-adatok/16-kozzeteteli-lista-integralt-szocialis/48-kozzeteteli-lista-pest-megyei-tophaz-egyesitett-szocialis-intezmeny).

The most recent budgetary information available is on the homepage of SZGYF. This resource is a complex document listing all institutions belonging to the Pest County SZGYF. From this complex table (http://www.pmik.hu/files/kozerdeku/szgyf_pest_megyei_intezmenyek_uvegzseb_20150731.pdf), see the relevant parts here (all amounts specified in Hungarian Forints – HUF):

CONTRACTING INSTITUTION	CONTRACTED	SUBJECT OF CONTRACT	DATE OF CONTRACT	EXPIRY	NET INVOICE	TYPE NAME
TOPhÁZ Speciális Otthon – Göd	Budapesti Elektromos Művek	Electricity transaction	2014. 06. 05	indefinite	7 891 324	Supplier Contract
TOPhÁZ Speciális Otthon – Göd	Dunamenti Regionális Víziközmű Rt.	Drinking-water supply, sanitation	2006. 01. 01	indefinite	7 007 874	Supplier Contract
TOPhÁZ Speciális Otthon – Göd	GDF SUEZ Energia MAGYAROROSZÁG zrt	Natural gas supply	2014. 07. 11	2015.07.01	22 820 247	Supplier Contract
TOPhÁZ Speciális Otthon – Göd	KEDVENC-JM Kft.	Food purchase	2014. 10. 03	indefinite	11 771 878	Supplier Contract
TOPhÁZ Speciális Otthon – Göd	Maros Építőipari és Kommunális Kft.	Municipal waste transport	2006. 02. 16	indefinite	4 181 777	Supplier Contract
TOPhÁZ Speciális Otthon – Göd	New Gold King's Bt.	Food purchase	2014. 10. 01	2015.03.31	8 869 740	Supplier Contract
TOPhÁZ Speciális Otthon – Göd	RST Sütőipari Kft.	Food purchase	2014. 10. 01	indefinite	13 574 818	Supplier Contract
TOPhÁZ Speciális Otthon – Göd	Stedra Kft.	Food purchase	2014. 10. 01	indefinite	14 551 181	Supplier Contract
TOPhÁZ Speciális Otthon – Göd	SZANTIN HÚS Kft.	Food purchase	2014. 10. 01	indefinite	12 603 375	Supplier Contract

TAKEN ON 18 APRIL 2017. © MDAC.



A male resident gnaws on the side of his bed.

TAKEN ON 9 MARCH 2017. © MDAC.

Young male with injuries to his arms. He was standing before seemingly falling asleep.

TAKEN ON 18 APRIL 2017. © MDAC.

Teenagers and men on one of the male wards.

Team members discovered that the institution has been a beneficiary of European Union Structural and Investment Funds under two schemes administered by the Hungarian Government: the "Szemünk Fénye Program" ("Light of our Eyes Program"), and another for energy modernisation at the institution.

2. FINDINGS

2.1. KEY FINDINGS

This section sets out key summative findings. To analyse these, key international human rights guarantees adopted by Hungary have been set out. Following this section, detailed observations and findings are presented for each of the five wards which were visited by the MDAC team.

(a) FAILURE TO PROVIDE FOR BASIC NEEDS AND DEBILITATION

Basic physical, emotional, psychological and social needs are not being met for the residents of Topház. The MDAC team clearly observed numerous cases of suspected malnutrition of adults and children, whose emaciated limbs, low energy levels and minimal responsiveness all indicated malnourishment. Several residents were confined to beds, with evidence of muscle atrophy and contractures, which can arise from long-term lack of activity, movement and/or physical therapies. MDAC saw one three-year-old child whose leg muscles were severely underdeveloped for his age, apparently unconnected with his congenital impairments.

Numerous adults and children showed signs of institutionalisation syndrome, potential sedation and profound boredom. The evidence for this was behaviours such as akathisia (rhythmic rocking), teeth grinding, gnawing furniture and chewing clothing. Adults were treated as infants and fed from baby's bottles. The MDAC team saw no evidence of education activities, nor any age-appropriate activities or stimulation for the development of children's cognitive, motor or social capacities. On all wards, residents overwhelmed the MDAC team with requests for human contact, attention and interaction, suggesting a significant deprivation of social interaction and isolation.

Conditions were deplorable. The team found appalling hygiene and insanitary conditions. Several wards were extremely cold. Excrement and urine were found on walls, sheets, beds, in bathrooms and in unwashed toilets. The physical conditions of flooring, walls, doors, bedding and furniture was generally poor and in some cases very bad.

Each ward contained approximately 40 residents with a variety of intellectual, developmental, mobility and physical impairments, as well as people with multiple and profound disabilities and complex care needs. Each ward had an average of two staff members on duty during MDAC's visit, and in one ward there was one staff member. The children's ward had an additional staff member who was cleaning floors. The team observed only minimal and superficial interaction between staff and residents, and no evidence of individual personal care except for the provision of medication.

HUMAN RIGHTS:

The findings represent clear violations of core international human rights protections for basic dignity and survival enshrined in international law and to which the Hungarian Government has committed itself. Many of these conditions, individually and/or cumulatively, may well breach minimum stands and engage the prohibition on inhuman and degrading treatment, under which international human rights law allows no justification:

- Right to life: CRC Article 6, CRPD Article 10, ICCPR Article 6, ECHR Article 2.
- Protection of the rights of the child from neglect or negligent treatment: CRC Article 19.
- Right to an adequate standard of living including adequate food, clothing and housing; the right to continuous improvement of living conditions and the right to be free from hunger: ICESCR Article 11, CRPD Article 28.
- Right to survival, development, dignity and human potential of the child: CRPD Article 24, CRC Article 6.
- Right to live independent and be included in the community for all persons with disabilities on an equal basis with others: CRPD Article 19.
- Right to an adequate standard of living including adequate food, clothing and housing; the right to continuous improvement of living conditions and the right to be free from hunger: CRPD Article 28, ICESCR Article 11.
- Right to a private and family life: ICCPR Article 17, ICESCR Article 10, ECHR Article 8, CRC Article 8, CEDAW Article 16, CRPD Article 23.

(b) RESTRAINTS AND SECLUSION

The MDAC team saw multiple and concurrent forms of restraint applied to several adult and child residents. Most prevalent was the apparent use of chemical restraint, evidenced by the laconic state of many residents, and their lack of responsiveness. Many people were sleeping during the daytime and did not wake up when the MDAC team entered. Other forms of physical restraint appeared to be applied for extended periods of time. These included cloth strapping, use of clothes such as leggings tied around the waist of one person and attached to the bed frame, socks used to restrict movement of forelimbs, hands and arms. In one case, the team found a child confined in a makeshift straightjacket fashioned from a jumper with the sleeves tied behind the child's back, restraining the child's arms so he could not move them outwards. Other residents, particularly those who were bed-bound, were in some cases tightly swaddled with bedding, restricting the movement of their entire bodies.

MDAC found that the personal liberty of residents was restricted due to all wards being locked, and found many residents in locked bedrooms. The door-handles had been removed from some bedrooms. As such, the doors could only be opened with the use of a portable door-handle by staff. MDAC was informed that only three residents had such handles. Most residents, therefore, were confined to their wards. The institution itself is surrounded by fending and an electronic gate controlled by a security guard.

Of major concern was the discovery of the placement of children and young adults in particularly confined metal barred cage beds. Such beds varied in height from the ground, and had sides of varying heights, ranging from just under one metre up to 1.5 metres in a deep bed. Although none of the beds had bars on the top, it was impossible for the child inside the cage to escape it without climbing, which was not possible due to physical impairments of most children. The youngest child discovered in a cage was three years old. None of the caged children or young people were supervised by staff. There was no mechanism for them to contact staff in case of emergency. In addition, two children were discovered confined to adapted wheelchair-buggies with multiple straps and were left unsupervised.

In some cases, the team found adults and children subjected to multiple and concurrent forms of restraint and seclusion.

HUMAN RIGHTS:

These findings raise violations of the right to personal liberty of all residents to the extent that they cannot leave their rooms, the wards or the institution freely. Additionally, the use of physical and chemical restraints further restricts their right to liberty on the basis of disability and is prohibited under international human rights law, falling foul of the absolute prohibition on torture and other forms of cruel, inhuman or degrading treatment or punishment. The UN Special Rapporteur on Torture has said that, in the context of institutionalisation on the basis of disability, "both prolonged seclusion and restraint may constitute torture and ill-treatment".[2]

- Freedom of liberty and security of person: ICCPR Article 9, ECHR Article 5, CRC Article 37, CRPD Article 14.
- Prohibition of torture and ill-treatment: ICCPR Article 7, ECHR Article 3, CAT Article 2, CRC Article 37, CRPD Article 15.

(c) VIOLENCE, ABUSE AND PUNISHMENT

MDAC found evidence suggestive of recent violence and abuse against the residents of Topház. These included numerous residents with visible and open wounds and other injuries. One boy's hand smelt like rotting flesh. Another boy had a black growth or infestation in his ear. MDAC gathered multiple testimonies of violence between residents and at the hands of staff. Several residents had untreated wounds on their faces and near their eyes. MDAC was also told of recent sexual violence and gender-based violence, including rape.

2 United Nations Human Rights Council, Twenty-second session, 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Méndez', A/HRC/22/53, 11 February 2013, para. 63, available online at http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf (accessed 26 April 2017).

The MDAC team heard allegations that staff had punished residents for misbehaving. Alleged punishments included forced cold showering in clothes for breach of rules, being forced to wear wet clothes afterwards, and being forced to kneel. MDAC was not able to verify these allegations, but they are all allegations that, to the best of MDAC's knowledge, have not yet been investigated by the police or other authorities.

While the placement of any child or adult in an institution increases the likelihood that they will be subjected to violence and abuse,[3] certain practices inside residential institutions further increase the risks faced by residents of Topház. Of particular concern to the team was finding children and adults placed on locked wards together – including on the "Children's Ward" – with minimal supervision. MDAC found a girl sharing the same bedroom with boys and an adult man.

HUMAN RIGHTS:

- Prohibition of torture and ill-treatment: CRPD Article 15, CRC Articles 2 and 37, ICCPR Article 7, ECHR Article 3, CAT Article 2.
- Physical and psychological autonomy: ECHR Article 8.
- Freedom from abuse and personal integrity: CRPD Articles 16, 17; CRC Article 19.

(d) DENIAL OF HEALTH, HABILITATION AND REHABILITATION SERVICES

Many residents of Topház, both adults and children, had poor physical health. MDAC documented several cases of suspected malnutrition requiring, in its view, urgent medical attention. Many residents had visible and untreated wounds, sores, scratches and black eyes, raising questions about whether residents even receive basic, general practitioner or emergency healthcare. Evidence of likely debilitation of residents was visible on all wards. Many residents showed signs of having been confined to beds for extended periods and of muscular atrophy and acute muscle contractures that render people unable to move without assistance.

Most residents had exceptionally poor dental hygiene, with many showing signed of advanced and untreated tooth decay, untreated sores and dental malformations.

MDAC observed how medication was handled. In one ward a staff member distributed pills using the same spoon to residents with a blob of sticky rice, one after the other. On a children's ward, medication was left unattended next to a child's bed. MDAC observed an injection being given without the staff person providing any information to the resident.

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3 Georgette Mulheir, 'Deinstitutionalisation – A Human Rights Priority for Children with Disabilities', *Equal Rights Review*, 9 [2012] 117-137; Manfred Nowak, 'Interim report of the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment' A/63/175, 28 July 2008, para. 38; and Mental Disability Advocacy Centre, *Cage Beds: Inhuman and Degrading Treatment or Punishment in Four EU Accession Countries*, MDAC (Budapest), 2003.

HUMAN RIGHTS:

Everyone has the right to the highest attainable standard of health. Governments must ensure basic, emergency, specialist and other healthcare services. This duty is enhanced in relation to people who are detained by the State, which includes the residents at Topház. In addition, persons with disabilities should be provided with services that enhance their independence, physical, mental, social and vocational abilities.

- Right to health and related services: ICESCR Article 12, ECHR Article 8, CRC Articles 23 and 24, CRPD Article 25, CEDAW Article 12.
- Right to habilitation and rehabilitation: CRC Articles 23 and 24, CRPD Article 26.

(e) DISCRIMINATION

Failure of the State to ensure that the residents of Topház can live in their families and communities with necessary supports and choices on an equal basis with others is a form of discrimination on the basis of disability. Residents of Topház have been detained in this segregating, isolating institution solely because of their impairments and are subjected to violence, abuse, neglect, ill-treatment and other rights violations set out above on this basis.

Moreover, the discrimination perpetrated in Topház is multiple and intersecting. The disproportionate impact of the placement and conditions in Topház on the children in this institution, the denial of their specific basic and developmental needs and the clear failure to act in accordance with their best interests amounts to age-based discrimination. The team found gender-specific abuses and violence, such as one woman who said she had been forced to spend the day naked to avoid having to wear soaking wet clothes and who was punished by being forcibly showered in her clothes in cold water. While the team could not determine with any certainty the ethnic origin of residents, it appeared that some residents may be of Roma and other ethnic origins, suggesting a need to investigate their particular circumstances from a point of view of racial equality.

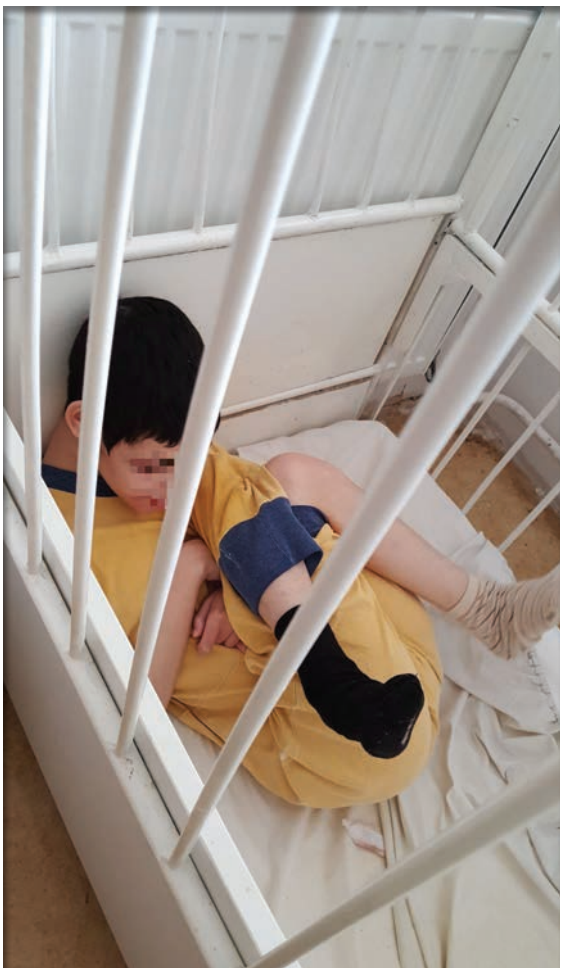
HUMAN RIGHTS:

The principle of non-discrimination and the right to equality are fundamental standards of international human rights law, found across all international treaties. They entail specific obligations for governments, such as, in the context of disability-based discrimination, the obligation to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind, to recognise that all persons are entitled without any discrimination to the equal protection and equal benefit of the law, to prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds, and to take all appropriate steps to ensure that reasonable accommodations are provided.

- Right to equality and non-discrimination: CRPD Articles 5, 6 and 7, CRC Article 2, ICCPR Article 2, ICESCR Article 2, CEDAW Article 2, CERD Article 2, ECHR Article 14 and Article 1 of Protocol 12 (signed by Hungary in 2000, although not ratified).

What follows is a detailed description of the findings from each of the five wards visited by the MDAC team.

TAKEN ON 18 APRIL 2017. © MDAC.



Female in her 20s in a cage bed with sides approximately 1.5m high.

TAKEN ON 18 APRIL 2017. © MDAC.

Woman with facial injuries on Female Ward A.

TAKEN ON 18 APRIL 2017. © MDAC.

Apparently malnourished teenage boy on Child Ward C.

2. “CSALÁD CSOPORT” / “FAMILY GROUP”

(a) ACCESS

Visit times: Approximately 10:25-10:45.

The door to this ward was locked upon arrival. Outside the entrance there appeared to be a number of broken pieces of equipment and rubbish strewn. One male member of staff unlocked the door and appeared to be the only staff member on the ward. The man greeted the team and sprayed some air freshener. He then left the team unsupervised until the end of the visit.

(b) FAILURE TO MEET BASIC NEEDS, DEGRADING TREATMENT

Approximately 15 residents were present on the ward during the team’s visit, mainly teenagers and young adults. All were physically mobile but a number appeared to be in a poor physical condition. Other residents approached team members and snatched some biscuits that the team had brought with them. Many appeared to be dressed in dirty and old, worn clothes. Several residents appeared to have slurred or slow speech and were either lying on the floor or were walking around very slowly. Both children and adults were kept together on this ward.

Apart from one half-broken television above the door in the common room, no education or other activities were observed on the ward. Residents appeared to be bored, with very low moods. They had nothing to do. No meaningful interaction was observed between the male staff member and residents.

Most residents present were in a common room where the semi-broken television played music and a few mattresses lay on the floor. Hygiene on the ward was extremely poor. The air smelled strongly of urine and faeces in both the common room and in a number of bedrooms that were visited. Many of the walls are covered with chipboard. A resident informed the team that this was because some of the walls and doors had been damaged by some of the residents.

The team saw a number of different bedrooms, including two single rooms and two larger rooms the latter of which have three beds each. All rooms were sparse, lacking any evidence of personal items, and some beds appeared to be damaged and without sheets.

It appeared that human body fluids (faeces or blood) that had been smeared onto some walls had not been cleaned.

The bottom half of the door to another room was missing, apparently damaged, and appeared to be smeared with faeces or blood.

Two bathrooms were both closed when the team arrived on the ward. Neither of them had door handles, but were opened by one resident of the institution who had a door handle that they carried around. When the bathrooms were opened for the team, it was warm and smelt of faeces and urine. One bathroom contained two toilet cubicles, a shower cubicle and a bath, yet there were no internal doors and therefore no possibility of privacy during usage. The toilets had no toilet seats and there was no toilet paper. Dirty liquid was on the floor.

The second bathroom contained one shower cubicle with a very dirty shower curtain and a toilet without a seat which appeared to have bright red stains in the bowl. We were told by two residents that this is a "sterile bathroom" which they can use for the purposes of kidney dialysis multiple times per day, however they both explained that it is filthy and dangerous for them to use. It was clear that basic hygiene standards for the safe provision of dialysis were not present, and as a result one resident instead opts to carry out dialysis in another resident's bedroom.

(c) VIOLENCE, RESTRAINT AND PHYSICAL INTEGRITY

One bedroom, which had just one metal bed frame, contained a newly-built wall that a staff member told MDAC had been replaced as it had been damaged by the resident in that room. Attached to the bed on the floor was a cloth strap which team members had previously seen tied around the ankle of this resident. A staff member told the team that this resident had been sent to a psychiatric facility in Vác and that the director of nursing didn't want him to return, although the staff member also expressed concern about this young man's overmedication expressing his view that the resident was, "afraid that his body cannot take any more, and that psychiatry cannot help him". Another young resident had serious swelling to the side of his face and complained about the pain.

Team members heard allegations from residents that sexual abuse is taking place on this ward, specifically that one boy was recently and regularly raped by another resident. The team were unable to substantiate this in the time available.

2.3. FEMALE WARD A

(a) ACCESS

Visit times: Approximately 10:50-11:35.

The front door of this ward was also locked when the MDAC team arrived. It was opened by a female staff member and the team observed only one other female member of staff on the ward during the visit. Following a brief introduction conversation, the MDAC team could move around the ward freely without supervision, however we found it difficult to leave the ward as the team could not attract the attention of staff for some five mins.

(b) FAILURE TO MEET BASIC NEEDS, DEGRADING TREATMENT

This ward has space for approximately 40 residents in a number of shared rooms, most of which contained six beds. Approximately half this number of residents were present on the ward when the team visited, although another group of 7 women came back to the ward towards the end of our visit.

Residents varied in ages from mid-teens to women in their sixties or older, and appeared to have a variety of physical, mental and multiple disabilities. A number were bed-ridden and others were seated in wheelchairs. Some other women were milling around with little to do. Although it was close to lunchtime, many of the residents were on their beds, and some were sleeping.

Three residents were rocking (akathisia): one while standing, another while seated

in a wheelchair and third who was on a bed. The team made several attempts to communicate with the woman on the bed, but she continued rocking in a rhythmic motion and lacked responsiveness. Team members were also particularly concerned to see another resident sleeping, who appeared to be malnourished and had injuries to her face. The team observed extensive rashes, scratches and bruising on the face of another woman.

Team members also noted that most of the women on this ward had very short hair, particularly those who were bed-ridden. Many residents showed evidence of poor dental and physical hygiene.

The physical condition of this ward was slightly better than at the Család Csoport, although much of the furniture and fittings were damaged or broken. Some of the bedrooms had wooden gates, approximately 1.5m high.

There was one separate storage room which was being used as a bedroom by one resident, and this room was filled with medical paraphernalia, cleaning equipment, machines and numerous black bags. In general, bedrooms were relatively sparse with little evidence of personal possessions. Each room contained some shared wardrobes and a few residents had bedside furniture. Although most beds were clean and had sheets, MDAC observed some lacked sheets and some had damaged mattresses.

There were two communal bathrooms with open shower cubicles, an open bath and three toilet cubicles in the same area. The floor was wet and in the middle of the floor of one bathroom MDAC found an adapted bed-bathing unit with no screening. Each bathroom was adjoined by two bedrooms, one on either side, with windows between the rooms meaning that people in the bathroom could easily be seen by people in the bedrooms. The toilets lacked any seats or toilet paper although it appeared there had been a rudimentary attempt to hang shower-type curtains above them, presumably to give some element of privacy. The curtains, however, were high up (approximately 1.80m) and it was not clear how residents with physical impairments would reach them without assistance. Some tiling was missing and the bathrooms were rather dilapidated.

(c) VIOLENCE, RESTRAINT AND PHYSICAL INTEGRITY

The team found one woman sleeping on a bed in a shared room. She appeared to be malnourished and had injuries to her face. On closer observation, it was apparent that the woman was tied around her waist with a pair of female stockings that was attached to the frame of the bed. She was sleeping and did not wake up as the team entered the room or when they attempted to talk with her. She had no blanket and was curled up on her bed, apparently wearing a one-piece makeshift cloth over other clothing and what appeared to be a diaper underneath.

One resident with physical impairments was confined to her bed and told a team member that she was scared on the ward in case a fire broke out and she would not be able to get away. Another resident told the team that one woman was punished and made to kneel for a period of time because she threw a plate. MDAC was not able to put this allegation to staff.

(d) HANDLING OF MEDICATION

MDAC did not observe much contact between the staff and the residents. During the visit, the staff had set up a trolley in the corridor of the ward to dispense tablets. One staff member had one spoon and a plate of sticky rice, and was using this to dispense tablets into the mouths of some of the women. There was no changeover of the spoon from one resident to the next.

The team also witnessed administration of medication by injection of one resident. The staff member did not describe what the medication was or its purpose, and the resident told team members that she didn't know what it was or the purpose. At no point was it observed that the staff member sought the woman's consent.

(e) GENDER-SPECIFIC ABUSES

A resident on this ward informed the team that she was required to go to the private bathroom of a male resident several times a day to undergo dialysis. She informed the team that she felt afraid for her safety on the ward with men. The team observed that the bathroom was filthy.

The team were also told about female residents who are required to assist with the provision of basic care on male wards, including intimate care such as changing men's diapers. Another woman told us that she felt fearful for her safety and asked a team member to raise the side bars on her bed.

Team members heard allegations that some residents in the institution (both male and female) were forcibly showered under cold water whilst clothed as a form of punishment. A female resident of this ward informed MDAC that she had no other option but to strip naked for the rest of the day to avoid extreme coldness and having to spend the day in wet clothes.

The team found no evidence of measures being taken to protect the residents from sexual abuse and had concerns about the safety of residents in this regard. No specific instances could be verified, and due to the highly sensitive nature of such concerns, MDAC were unable to investigate further.

2.4. CHILDREN'S WARD C

(a) ACCESS

Visit times: Approximately 11:40-12:40.

The front door of this ward was locked on the arrival of the MDAC, but was opened after knocking on a few occasions. Three female staff appeared to be present on the ward during the visit around lunchtime, one of whom was cleaning the floors. This ward had space for approximately 40 children in rooms with six beds, although team members identified several residents who appeared to be adults.

(b) FAILURE TO MEET BASIC NEEDS, DEGRADING TREATMENT

Team members saw many children and young people with visible physical health issues, including:

- A child in a whole-body garment who appeared seriously malnourished;
- A young child with malformed tooth structure and who was complaining about pain from blisters in and around her mouth; another child who had a sore on his hand which, when opened, had a pungent rotting smell;
- A child in a metal-sided cage bed with extremely thin arms and legs who appeared seriously malnourished; and
- Several children who showed signs of distress and neglect, including one child who was standing in a metal-barred cage bed rocking backwards and forwards (akathisia), and other children who were covering their faces with their arms and hands.

Although there were some toys and colourful images on the walls, the bedrooms and ward had little additional furniture or other features. One child's head was propped up on a fluffy toy in what the team interpreted as an apparent attempt to help him see and breathe, although it is not clear that this was a safe technique. One bedroom had six beds, each of different types (two wooden-framed beds, a single metal-barred cage bed with sides estimated at just over a metre high, two others which looked like adapted hospital beds, and a metal framed bed). The room had only one female resident who shared it with four teenage boys and an adult man. The room was partially closed by a wooden fence on the door and dirty water was visible on the floor. Apart from the beds, a single wooden table in the middle of the room and a small side table, there were no other furnishings in the room.

The complete lack of stimulation was palpable. A female child stood almost motionless in the middle of the room with very dark eyes, chewing on a piece of clothing. A boy lay motionless on one of the beds and did not even respond to "hello". The apparently adult male resident appeared not to be wearing trousers but had a diaper and reached his arms towards the door when the first team member arrived.

Another room contained six beds, each with a child lying on their backs. The beds were so close together that they touched.

(c) VIOLENCE, RESTRAINT AND PHYSICAL INTEGRITY

Of serious concern was that over 15 metal barred cage beds were observed of different sizes, with metal side bars between one and 1.5 metres. The majority of these cage beds were occupied by children and young adults. In one case, a ten-year-old child was in a cage with metal bars approximately one metre in height. In another room, six child residents all appeared to be placed in different sized metal barred cage beds, although the sides were lower (between 30 and 60cm).

The team also observed one young woman who MDAC were told was 20 years old in a cage with metal bars approximately 1.5 metres high who appeared to have facial injuries and was sitting on a urine-stained sheet.

Two children in metal-barred cage beds had muscular contracture of the arms and had large socks placed over their hands and forearms. Another teenager appeared to be placed in a full-body piece made from what appeared to be handstitched fabric, and both his hands were also covered with socks. All three of these children appeared to be sleeping in the middle of the day.

Two pre-adolescent children were found sitting in adapted wheelchair-buggies with no supervision by staff. Both were strapped in at multiple points around their chests, waists and legs. The children both expressed pleasure when team members showed an interest in them.

(d) HANDLING OF MEDICATION

In one room, team members observed that several tablet boxes were left on a table next to four baby-feeding bottles, a water jug, some plastic cups, a spoon and a pestle-and-mortar which appeared to have a white powder residue inside. The table was touching two beds in which children were lying.

(e) CHILD-SPECIFIC ABUSE

Many children and young people appeared to have different levels of muscle and spinal contractures. A young boy who was completely immobile could only move his head a few millimetres, his head positioned to face an adjacent bed so it was impossible for him to see the team members' faces or to make eye contact. He was at first wary when touched, but began to smile and laugh when his cheek was caressed. Another teenage boy with significant spinal contracture attempted to lift himself off a bed to communicate with team members but was unable to do so unaided and fell back onto the bed.

The team interacted with one child who was three years old and who was in a metal barred cage bed, but who was released by a staff member to play with us. Although his impairment did not appear to be related to his legs, he was not able to walk unaided and the team noted that his leg muscles were under-developed, soft and almost hypotonic. They appeared not to be able to bear his body weight. However, with assistance to stabilise himself, the child could stand up and take steps, was happy, social and active for the whole period that team members engaged with him.

2.5. MALE WARD 'B'

(a) ACCESS

Visit times: Approximately 15:28-15:45.

The MDAC team arrived at the front to this ward which was also closed and locked in mid-afternoon. After knocking on the door several times, one female staff member came to open the door to provide access. She and another female staff member were in a rush and appeared not to want to speak with MDAC, leaving the team to go around the ward alone.

(b) FAILURE TO MEET BASIC NEEDS, DEGRADING TREATMENT

The conditions appeared particularly harsh from the moment of entry onto this ward, with a number of young men with various physical impairments seated or laying on the floor, and others milling around the entrance. Team members were particularly concerned to see that many residents on this ward had visible and untreated injuries to their hands, faces and bodies. One teenager with Down syndrome was sitting on the floor next to the entrance of the ward when MDAC entered and was still there when they left approximately twenty minutes later. His hands were noticeably reddened.

Another young man with Down syndrome was found on the floor beside a bed and with his hands over his face. Team members were seriously concerned for this young man who was not moving, had atrophied legs, very reddened hands, and eyes closed. Team members thought he may be dead, so immediately alerted staff. Before a female staff member arrived, another large male resident came to the room, picked up the man with Down syndrome and put him on the bed. When the staff member arrived, she chastised a resident who helped, saying that the young man preferred to be on the floor while eating. Team members saw no evidence of food apart from a baby bottle on the floor a metre or so from his head. The young man remained minimally responsive, even after being moved.

In the same bedroom, another man was lying in a foetal position on a bed, with his hands covering his face. He seemed to be distressed. A teenage resident of this room was left sitting in a wheelchair facing a table which had baby toys on it which were not appropriate for his apparent age. He had redness on both of his feet which were bare. An empty cup sat in front of him. Also in the same bedroom was an older teenage boy who had exceptionally thin arms and legs, was sitting up and awake but virtually unresponsive. He appeared to be seriously malnourished.

Another bedroom on the ward was opened for the MDAC team. This room had three older adult residents, all confined to their beds. One apparently middle-aged gentleman held a baby's bottle and had very dry skin around his face. Another resident appeared to have significant muscle contractures and atrophied limbs. He was sleeping at the time of our visit however the wooden frame of his bed had been seriously damaged by his tooth marks from long-term gnawing, which the team had observed on a previous visit. He was not fully clothed, and wore a diaper without trousers. Another man in this room was also sleeping horizontally across his bed with his atrophied legs and feet protruding through the metal sidings of the bed. He also appeared not to have trousers, was wearing a diaper and was swaddled in a sheet, restricting movement.

Many residents were present on this ward, which was cold. They sat on the floor, groaned and were in various poor states of dress and undress. MDAC saw residents huddled in inadequate clothing, wearing shoes in their beds. Some residents appeared to be wearing handmade clothes comprised of un-matching bedclothes which were sewn together, apparently rendering them difficult to remove. Approximately eight male residents, ranging from young teenagers to adults, were in a "common room" which was bare except for one broken bed and a dilapidated garden bench with a cartoon painting on the wall. At least three residents were in wheelchairs and appeared to have atrophied legs.

The ward had a chaotic feel because there was little supervision. No activities were observed and there was no private spaces for residents apart from shared bedrooms along a dark central corridor.

Each room had approximately six beds of various wooden and metal styles. Many of the rooms contained boys and adults who were immobile, lying on their beds. Most were awake but were either unresponsive or minimally responsive to the presence of the team. Previous experience of team members suggests this may be due to lack of stimulation and the effects of psychotropic or other sedative medication. MDAC was not above to verify this hypothesis.

Flooring in many rooms, as well as in the shared bathrooms, were in a poor and dirty condition, and had holes and scratches. In the bathroom, which was similar in layout to those on other wards, team members found shoes and clothes jumbled on a shelf. It was not clear whether these were personal items of specific residents or were a communal pool.

(c) VIOLENCE, RESTRAINT AND PERSONAL INTEGRITY

One teenager with Down syndrome was found to be in a very bad physical state, with clear and recent injuries to his face, dried blood and back eyes, severely atrophied legs and an unknown black substance in and around his ear, emitting a pungent odour.

Most doors to bedrooms on this ward were closed and had no handles. The doors to these rooms could only be opened by people who had a handle which could be inserted in the door, acting like a key. When MDAC gained entry, its team found boys and young men locked inside unsupervised and particularly shocking conditions.

Other than residents being locked into their rooms, the team discovered one egregious case of multiple physical restraint of a child who was likely between 11 and 13 years old. He was standing in the middle of the room staring and grinding his teeth rhythmically. His teeth and gums were seriously malformed and in very poor condition. He appeared to be wearing a home-made straightjacket. This garment had been fashioned from a long-sleeved jumper with the sleeves of the jumper tied behind his back. His arms and hands were visibly moving underneath the front of his jumper. His movement was extremely limited indicating that he was possibly further tied underneath the makeshift straightjacket. He also had a helmet on his head, covering the sides of his face in front of his ears. His face was distorted with injury. He had black eyes, and his face contained cuts, swelling and bruising. Swelling, redness and cuts were all evident on his bare feet and ankles. The boy was clearly highly distressed. Another resident informed the team that this boy was “non-verbal”.

2.6. MALE WARD 'D'

(a) ACCESS

Visit times: Approximately 15:48-16:10.

The front door to this ward was closed and locked. Two female staff members opened the front door and granted access to the MDAC team after a short discussion, following which the team could move around the ward unhindered.

(b) FAILURE TO MEET BASIC NEEDS, DEGRADING TREATMENT

The residents ranged from teenage boys to adult men. The ward was noisy and around 15 residents gathered in a "common room". This area had a couple of beds, a couple of tables and a few broken chairs. Nothing was on the tables, on which some residents were sitting, and on the floors. The ward felt cold, was noisy and chaotic, and the physical environment in both the common areas and the bedrooms was dilapidated. Some of the rooms had smells of bodily functions including fresh urine. Several residents sat on the floor. One boy lay in the corner next to a radiator, and another lay bare-chested. One young man in the corridor appeared to be dressed in pyjama trousers which were sewn to a mismatched top. Another resident in similar clothing was bent double on the end of a bed which was shared with another resident, huddled towards the radiator.

Similar to other wards, the windows in rooms had nets and bars visible on the outside. One room had a door out onto a terrace corridor. The terrace was an open-air corridor fenced in by metal bars. A staff member informed the MDAC team that residents were sometimes taken there in good weather. Damaged bedding, mattresses and other debris were strewn across the floor.

Much of the bedding seen in rooms on this ward were bare, damaged and filthy. On a bed in one exceptionally sparse and cold room, the MDAC team found a teenage boy swaddled in a filthy, damaged duvet. He appeared to be shivering. He wore shoes even though he was in bed, presumably to keep warm. The MDAC team estimated the temperature inside the room to be between 10 and 12 degrees Celsius.

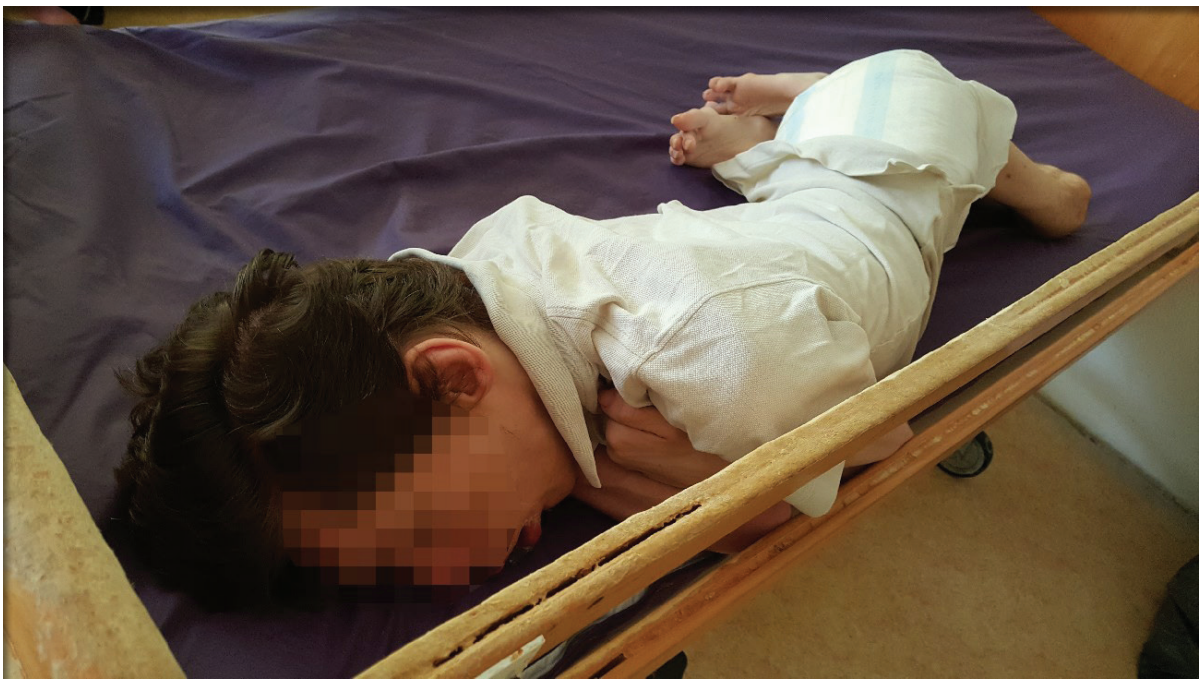
Only in one room did the team find a television. It was unclear whether this was in working condition. No other activities appeared to taking place on the ward.

(c) VIOLENCE, RESTRAINT AND PHYSICAL INTEGRITY

Many of the residents appeared to be in a very poor physical condition, with several having obvious physical injuries, sores or scarring. One young man in the corridor had a shaved head and appeared to have extensive abrasions and scratch marks to his arms, reddening on his face, a malformed or extremely swollen ear that may have been the result of an injury, and sores around his face.

Another young man with Down syndrome was seated in the middle of the common room floor and had numerous abrasions and injuries to his forearms. Although sitting up he was entirely unresponsive apart from fiddling with a piece of cloth. He also appeared to have sores and swelling to his face.

TAKEN ON 18 APRIL 2017. © MDAC.



Adult man on one of the male wards, sleeping during the day, without adequate clothing and displaying muscular atrophy and contracture.

TAKEN ON 27 FEBRUARY 2017. © MDAC.

Young male with a cloth strap around his ankle attached to the metal frame of his bed on the Család Csoport Ward.

APPENDICES

ACCESS TO THE INSTITUTION

MDAC has repeatedly attempted to gain access to conduct monitoring visits in Topház via the Directorate-General for Social Care and Child Protection ("*Szociális és Gyermekvédelmi Főigazgatóság*", SZGYF), an agency under the Hungarian Ministry of Capacities since May 2016. Our attempts to secure access to this institution include the following.

On 26 June 2016, MDAC telephoned and exchanged emails with Mr Tamás Formanek, the then director of Topház, requesting permission to conduct a monitoring visit on 5 July 2016. Mr Formanek expressed openness to collaborate, but subsequently, on 28 June 2016, denied access to MDAC to carry out the planned visit.

On 1 July 2016, MDAC wrote to Mr Zsolt Bátori, Director of SZGYF, requesting a meeting to discuss MDAC's project and seeking official permission to visit child care institutions maintained by the authority. We wrote again on 2 August and 31 August 2016 and followed up by phone on 31 August 2016 and 1, 2, 6 and 9 September 2016. On 20 October 2016, we sent a letter to Mr Károly Czibere, State Secretary for Social Affairs and Social Inclusion asking for a personal meeting to discuss access to residential social care institutions. On 3 November, we subsequently wrote a letter to Mr Zoltán Balog, the Minister of Human Capacities, referring to our previous letters to both Mr Bátori and Mr Czibere. In this correspondence, we asked repeatedly for access to four specific residential social care institutions, including Topház. Copies of this correspondence were also sent Mr László Székely, the Hungarian Ombudsman, Dr Gergely Tapolczai, a Member of Parliament and Chairperson of the Parliamentary Group on Persons with Disabilities. The correspondence was also shared with various international monitoring bodies and stakeholders.

MDAC contacted a number of Members of Parliament who also have constitutional authority to enter public institutions to ask them to intervene. On 15 November 2017, a Hungarian MP agreed to lead a visit to the institution with an interdisciplinary team of monitors trained and coordinated by MDAC. Prior to the visit, MDAC informed the relevant authorities of the planned visit and we were subsequently informed that Tamás Formanek, the previous director, had been removed from his post. The strategy to access Topház, however, was unsuccessful. Upon arrival, Mr István Zsolt Benedek (Deputy Director of SZGYF) stood in the door of the institution with a new director, Ms Judit Lantosné Berkes and the head nurse and refused access to the monitoring team. The Member of Parliament phoned Mr Imre Nyitrai, Deputy State Secretary for Social Policy, reminding him of the importance of the human rights monitoring. Subsequently the MP was allowed in for a short period but the human rights monitoring team were denied access.

MDAC is also a member of a Civil Consultative Body (CCB) to the National Preventive Mechanism (NPM), an office of the Hungarian Ombudsman which has a legal mandate to enter and inspect all places of detention under the jurisdiction of the country. NPMs are established by countries in compliance with international legal obligations under the Optional Protocol to the UN Convention against Torture (OP-CAT), which Hungary ratified in 1987. Due to the issues in gaining official access, MDAC recommended that the NPM visit Topház, which we understand took place in January 2017. Despite this visit, no report has yet been made public.

In February 2017, MDAC once again sought access in order to identify children or adults with disabilities who could speak about their lives at a conference. Our request was accepted and MDAC conducted several preliminary visits with the purpose of getting to know the residents.

On 18 April 2017, the team entered by pre-arranged appointment, however the staff contact was not present in the institution that day. Access was granted by the security guard on the gate. The team then had free access to all parts of the institution with minimal supervision. Access was provided to each of the closed wards by staff who were present and who unlocked doors when team members knocked at the entrances.

PREVIOUS FINDINGS

On 15 February 2017, MDAC team members identified a very worrying situation regarding one young adult resident with an intellectual disability who was strapped to his bed in exceptionally poor conditions. MDAC made the decision to pass this information on to the office of the Ombudsman. We were informed that the Ombudsman had undertaken a visit to the institution on 19 January 2017, was aware of the concerns raised, and would issue a report at an unspecified time in the future. To date, no such report has been released. The resident continued to be present on other visits, although was not present on 18 April 2017.

In June 2002, the Commissioner for Human Rights of the Council of Europe conducted an official visit to Hungary,[4] during which time he visited Topház. The Commissioner noted that there were 220 child residents (although he saw some who he believed to be older), and that many residents appeared to be "very badly ill".[5] He noted that the institution appeared to be "showing its age", and he recommended that such institutions should "immediately be provided with the necessary material and human resources, as appropriate, as well as financial resources corresponding to their needs."[6]

On 20 May 2014, a national Hungarian media outlet (index.hu) published a story with numerous images about Topház entitled 'Those who were rejected by the system' ('Akiket mindenhonnan kitaszít a rendszer').[7] The story, which depicted a number of individual residents, described the challenges faced by staff in caring for people with disabilities who have been abandoned by families and wider society. It stated that "[m]ost inmates spent their entire lives in Topház, and it is rare that any of the residents are accepted by adoptive families or moved to another social institution."[8]

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4 Commissioner for Human Rights of the Council of Europe, 'Report by Mr Alvaro Gil-Robles, Commissioner for Human Rights, on his visit to Hungary, 11-14 June 2002, for the Committee of Ministers and the Parliamentary Assembly', CommDH(2003)7, available online at https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806da9fe (accessed 26 April 2017), pp. 125-138.

5 Ibid, para. 22.

6 Ibid, para. 23.

7 Anna Csonka and János Bődey, 'Akiket mindenhonnan kitazít a rendser', index.hu, 20 May 2014, available online at http://index.hu/nagykep/2014/05/20/godi_gyermekotthon/ (accessed 26 April 2017).

8 Ibid.

In July 2014, a subsequent Commissioner for Human Rights of the Council of Europe, Nils Muižnieks, conducted a visit to Hungary.[9] Although he did not visit Topház, he noted concerns about plans to both build and refurbish large residential institutions for persons with disabilities.[10] He recommended that authorities should "immediately stop placements in institutions" and that EU Structural and Investment Funds should "not [be] used to renovate or build large institutions for persons with disabilities or other accommodation not complying with the requirements of the UN CRPD [United Nations Convention on the Rights of Persons with Disabilities]".[11]

METHODS USED

MDAC has extensive experience of documenting and investigating the human rights of people with disabilities. Although the findings in this report are not based on a comprehensive monitoring visit, the following methods were used in the collection of information.

1. OBSERVATION: All five wards of the main buildings of the institution were visited on the same day in the following order – Család Csoport, Female Ward 'A', Children's Ward 'C', Male Ward 'B' and Male Ward 'D'.
2. INTERVIEWS: The team communicated with many residents during the visit to the institution.
3. DOCUMENTATION: The team was not provided with access to any documentation during the visit to the institution.
4. MEDICAL CONSULTATION: MDAC consulted a doctor with relevant expertise to provide opinions based on images that were taken during the visit.

The bulk of findings in this report are based on a visit to the institution on 18 April 2017 by a team of representatives from MDAC. Some of the observations in this report have been supplemented by observations made on previous visits on 15, 17 and 27 February and 9 March 2017. Given the serious levels of abuse and neglect found on these visits, MDAC has taken the decision to make this report public, to give the authorities an opportunity to quickly put right the terrible situation in which people are living in Topház.

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9 Commissioner for Human Rights of the Council of Europe, 'Report by Nils Muižnieks, Commissioner for Human Rights of the Council of Europe, following his visit to Hungary from 1 to 4 July 2014', CommDH(2014)21, 16 December 2014, available online at https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?coeReference=CommDH(2014)21 (accessed 26 April 2017).

10 Ibid, paras. 116-7.

11 Ibid, para. 124.

TAKEN ON 18 APRIL 2017. © MDAC.

A teenage boy with Down syndrome, open cut on forehead, black substance in his ear and with signs of malnutrition.

TAKEN ON 18 APRIL 2017. © MDAC.

The enclosed outdoor terrace attached to one ward.

TAKEN ON 18 APRIL 2017. © MDAC.

Woman on Female Ward A who had injuries to her face. She was sleeping and upon closer inspection we found that she was tied to the bed with stockings. Also showing signs of malnutrition.