Õiguskantsler

Mr Agris Peedu
Chairman of the Board
North Estonia Medical Centre
info@regionaalhaigla.ee

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Inspection visit to the North Estonia Medical Centre Foundation psychiatric clinic

Dear Chairman of the Board,

On 12 October 2021, advisers to the Chancellor of Justice carried out an unannounced inspection visit to the third and fifth department of the North Estonia Medical Centre Foundation psychiatric clinic (hereinafter 'the clinic').

The Chancellor last inspected the clinic on 9 February 2019 when the visit focused on the seventh department. A couple of years before that (see the summary of the inspection visit of 11 February 2017) the fourth and fifth department were inspected. In comparison to 2017, the hospital has started keeping more careful documentary records of the reasons for applying means of restraint. Carers and nurses monitor the condition of a patient under restraint and record on a separate sheet their observations and information about procedures carried out (e.g. when the patient was given something to drink).

It is commendable that activity supervisors are present in the building wing of the third department (acute treatment department). Working arrangements of trust nurses left a good impression. Nurses constantly interact with patients and closely cooperate with patients' attending doctors. Under the guidance of nurses, meetings of so-called health groups are organised where patients can discuss healthy lifestyles and other issues important for them. The clinic offers people a possibility to vaccinate against the coronavirus as well as vaccine counselling. The staff at both departments said that they felt safe at work since usually several people are at work simultaneously and the team is supportive. Upon completion of hospital treatment, a patient is offered the possibility to fill out a satisfaction survey.

Unfortunately, in both departments documents on applying means of restraint are still filled out in handwritten form, so that sometimes it is difficult to understand what was written. Chemical restraint is not always reflected in the form on applying means of restraint.

Equipment used for restraint should not cause injuries to a patient. Should injuries still occur, these must be documented. Appropriate clothing must be ensured to a patient when applying means of restraint. Use of handcuffs as a restraining measure is not appropriate, nor may excessive force be used towards a patient under restraint. To prevent ill-treatment, security staff must be trained for

work with people with mental disorders and it should be ensured that they always act under guidance from the medical personnel.

The mailbox for submitting complaints must be clearly marked. All wards must have doors and each ward must be properly furnished. Patients must be enabled to meet their next of kin and communicate in private by telephone.

Use of video surveillance in a ward must be assessed on a case-by-case basis. Video surveillance may only be applied if unavoidably necessary.

Some problems are still caused by the fact that psychiatric care is provided in old buildings where it is complicated to create an environment meeting the standards of a modern psychiatric hospital. According to initial plans, the clinic was to move into a new building in 2023 but probably these plans cannot be fulfilled. The head of the clinic expressed hope that moving to new premises will take place in 2025.

The Chancellor's advisers and the healthcare expert inspected the clinic's rooms, interviewed hospital staff and patients and examined documents and video recordings.

The fifth department (acute treatment department) has 30 beds: 15 places are for women and 15 places are in the male wing of the building. On the day of the inspection visit, 20 patients were receiving treatment (11 men and 9 women). One patient was under voluntary treatment, the remaining patients were receiving involuntary psychiatric treatment.

The third department (the subacute treatment department) has 46 beds: 22 on the first floor and 24 on the second floor, of which 12 beds were adjusted for Covid-19 infected people. In the third department, treatment is given to patients with chronic psychotic disorders who do not need treatment in the acute treatment department. On the day of the inspection visit, 33 patients were under treatment in the third department, of whom 21 were under involuntary treatment, 11 were in the hospital voluntarily, and one person had been placed in the hospital mandatorily for a forensic psychiatric assessment. No patients were in the department for corona-infected persons. Both male and female patients can be placed in this department. In an ordinary situation, the relevant department is intended for female patients while the remaining third department is intended for male patients.

1. Living conditions

In both the third and fifth departments some wards had no doors. The staff explained that the doors had been removed for security reasons as this allows the staff a better overview of what is happening in the department.

During interviews, patients mentioned that absence of doors very much annoyed them. They also conceded that they would prefer to be in single- or double-occupancy wards. Since there are no doors, people in the wards could hear noise from the corridor, which may disturb those patients wanting to have a rest at that moment. Due to the absence of doors, patients do not have enough privacy since they are constantly within the sight of staff as well as other patients. The Chancellor understands that the hospital wishes to ensure security of people under treatment. However, ensuring security must take into account patients' other needs and rights.

The Chancellor has emphasised that in essence a patient's ward is their private area even when they share it with another patient. This means that a ward is a place where a patient must be able to have a rest from the overall hustle at the department and be on their own. People may also wish to carry out private procedures in a ward, for example change clothes, speak to their loved ones on the phone, and the like.

Patients in need of psychiatric care are entitled to treatment and nursing on an equal footing with other patients (§ 4 clause 1 Mental Health Act). It is reasonable to assume that a patient's ordinary accommodation conditions are of the kind that also enable a ward door to be closed. The Chancellor understands that the behaviour of a psychiatric patient may be unpredictable and dangerous due to their health condition and may also require monitoring of a patient's private activities. However, enhanced monitoring must be based on a risk analysis related to a particular patient but should not be applied automatically to everyone admitted for treatment.

The Chancellor asks the clinic to re-install the missing doors in wards.

The acute treatment department has two observation rooms where a person can be mechanically restrained if necessary. A single-occupancy observation room is located in the female building wing and a double-occupancy observation room in the male wing. There was no wall clock in the single-occupancy observation room. The healthcare expert participating in the inspection visit noted that a patient under restraint should have a clock within view, otherwise they may lose all sense of time and get confused. For a patient who wishes to submit a complaint against staff activities, it is useful if they know when the incident they describe took place in order to establish the facts.

Furnishings in the acute treatment department are austere: wards are clean but scantily furnished and there are no items to create a cosy atmosphere. The female building wing is somewhat cosier – for example, wards there have murals. Several wards in the acute treatment department were missing mandatory furnishing elements (chairs, spot lights). Nor did the wards have lockable cupboards to store personal belongings. Valuables can be deposited at the department.

The expert participating in the inspection visit noted that the physical hospital environment has a strong effect on a patient's recovery. The acute treatment department should be made cosier, as this has a therapeutic effect on patients. The Chancellor has also dealt with the importance of a therapeutic environment in the summary of the inspection visit to Viljandi Hospital Psychiatric Clinic. The conclusions and recommendations presented in that summary also apply to the North Estonia Medical Centre psychiatric clinic. Certainly, furnishing hospital rooms for patients in an acute and unstable condition is a complicated task but flexible solutions for this should be found. For instance, framed paintings may be replaced with murals, or patients themselves may be allowed to draw on the walls (e.g. temporarily turning a wall into a board, or the like). Some furnishing elements may also be removable (e.g. bean-bag chairs, or the like).

Patients in the acute treatment department can place their complaints and proposals in a mailbox, one of which is located in the female and the other in the male building wing. The opening of the mailbox in the female wing is located in front of the door while the box itself is on the other side of the door. The mailbox in the female wing had no specific marking. Therefore, patients might not understand its purpose.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has emphasised in its standards[1] that, in order to prevent ill-treatment, it is extremely important to offer patients a possibility to lodge complaints with the treatment establishment or an independent body. For this reason, it should be ensured that patients are informed how and where they can lodge complaints.[2] The CPT has noted[3] that patients must have easy access to complaint boxes and such a box should be available in each unit of the establishment.

The Chancellor asks the clinic to supplement the furnishings in the acute treatment department so as to offer patients a therapeutic environment. Mailboxes for lodging complaints must be clearly marked. The observation room should have a clock.

2. Video surveillance in the acute treatment department

Video surveillance in the acute treatment department is applied in almost the same way as during the previous inspection visit: it is extensive and also used in wards. The only improvement has been in informing patients about the extent of video surveillance. The staff at the acute treatment department cannot view the video feed in real time since no technical possibilities for this exist. The video feed is recorded in the main building of the North Estonia Medical Centre (at the Mustamäe medical campus) and is retained for 30 days. In the case of justified need, the head of the acute treatment department can access the recording.

Since the clinic has not made any substantive changes in applying video surveillance, the opinion and recommendations expressed in the summary of the Chancellor's previous inspection visit are still relevant. The Chancellor has dealt with use of video surveillance in several summaries of inspection visits to hospitals.[4] These observations also apply to the clinic.

Since the clinic staff cannot view the live video feed from surveillance cameras, video surveillance does not fulfil the purpose of preventing or controlling a patient's dangerous behaviour. Consequently, constant video surveillance applied in patient wards is a disproportionate measure since general security can be ensured by measures less restrictive of privacy (e.g. by applying video surveillance only in communal rooms).

In its country recommendations, the CPT has expressed the opinion[5] that use of video surveillance in patient wards constitutes a gross intrusion into the privacy of patients. The decision to use video surveillance must be based on a risk assessment related to an individual patient.

The Chancellor asks that use of this kind of video surveillance system be immediately stopped.

3. Hospital clothing

Patients in both the third and fifth departments were wearing hospital clothes and patients in the fifth department also underwear provided by the hospital. The hospital additionally provides

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[1] See para. 53.
[2] See e.g. the CPT's 2019 visit to North Macedonia (para. 159).
[3] See e.g. the CPT's 2015 visit to Armenia (para. 138); the CPT's 2017 visit to Bulgaria (para. 136).
[4] See e.g. the Chancellor's inspection visit of 5 May 2018 to the mental health centre for children and young people at the Psychiatric Clinic of Tartu University Hospital Foundation; the Chancellor's inspection visit of 9 November 2019 to the Psychiatric Clinic of Pärnu Hospital Foundation; the Chancellor's inspection visit of 22–23 October 2020 to the coercive treatment department of the Psychiatric Clinic of Viljandi Hospital Foundation.
[5] See e.g. the CPT's 2019 visit to Bosnia and Herzegovina (para. 119), the CPT's 2020 visit to Moldova (para. 120).

patients with outdoor clothes (coats, hats, scarves) and footwear. People's own clothes are deposited in a locked wardrobe during their treatment.

Under internal departmental rules, a patient is entitled to wear hospital clothes. However, in practice this is not a right that may be waived but a duty since arrangements concerning clothing are not flexible. Interviews with patients revealed that they perceived wearing hospital clothes as an inevitability inherent in hospital treatment but not a choice. According to staff, it is more convenient for patients themselves to use hospital clothes during treatment since in that case the person's own clothes do not get soiled (e.g. while walking in the department yard in poor weather).

Based on international recommendations, the Chancellor has emphasised[6] that psychiatric patients consider the opportunity to wear their own clothes to be important. Hospital clothes could be provided to those who so wish or who have no suitable own clothing when admitted for treatment.

The Chancellor asks the clinic to take into account that patients are also allowed to wear their own clothes. Hospital clothing should be provided to those who so wish or need them.

4. Contact with next of kin

The department does not have separate rooms for meetings with next of kin. Meetings can take place either in the canteen, the lobby or a corridor. To combat the spread of the SARS-CoV-2 coronavirus, only vaccinated or recovered family members and friends were allowed to visit patients.

Patients in the acute treatment department are not allowed to use their personal mobile phone. Phone calls can be made on the departmental phone between 15.00–19.00. On the second floor of the third department, a personal mobile phone may be used twice a day (one hour in the morning and one hour in the evening), while patients on the first floor can use mobile phones from the morning to 21.00. If a patient in the third department does not have a personal phone, they are allowed to make short calls on the hospital phone.

A member of departmental staff is always present during phone calls and visits involving patients in the acute treatment department. The staff explained that they checked what number a patient dials in order to prevent unnecessary calls on the emergency number. The staff member present during the conversation also monitors the patient's condition and stops the conversation if the patient gets agitated. In the opinion of the staff, a person's attending doctor may impose restrictions on the person's communication if it is noticeable that interaction with next of kin or a friend negatively affects the patient's health.

Patients must be afforded privacy during telephone conversations as well as during visits. If a hospital staff member is present during a conversation between a patient and their next of kin, this violates the patient's right to inviolability of private life (§ 26 Constitution of the Republic of Estonia).

The Chancellor is of the opinion that, in order to ensure security, hospital staff may monitor a patient's meeting with a visitor or a patient's telephone call but this must be done in a manner that enables the confidentiality of messages between the patient and their conversation partner to be

[6] See section 1; see also the CPT's 2012 visit to Estonia (para. 113); the CPT's 2019 visit to Ireland (para. 116), the CPT standards (para. 34).

maintained.[7] For instance, a meeting can be monitored via video surveillance. This ensures the confidentiality of conversations between a patient and their next of kin but medical personnel maintain the possibility to intervene if the situation so requires (e.g. the behaviour of the patient or visitor becomes dangerous). The CPT has also accepted[8] an arrangement where staff monitor a patient's visit from aside.

A patient's attending doctor cannot prescribe with whom the patient may or may not communicate. The staff opinion that a doctor is entitled to do so is incorrect. Of course, the hospital is entitled to lay down in their internal rules a reasonable time and place for visits and phone calls and take certain measures to prevent unlawful behaviour by patients (e.g. unnecessarily calling emergency services). Visitors can also be required to comply with rules intended to ensure security (e.g. not to bring along prohibited items, or the like). However, a healthcare service provider is not entitled to restrict the range of people with whom a patient wishes to communicate because this interferes with the patient's right to inviolability of private life (§ 26 Constitution). Only a patient themselves is entitled to refuse to meet a visitor or accept a phone call. The Chancellor has also dealt with the issue of restrictions on communication in the summary of the inspection visit to the coercive treatment department of the Viljandi Hospital Foundation psychiatric clinic. The observations made in it also apply to the North Estonia Medical Centre psychiatric clinic.

The absolute ban on possession of mobile phones in the acute treatment department contravenes the law. The Chancellor has drawn[9] the attention of hospitals to the fact that restrictions on possession of items laid down on the basis of § 9^1(2) of the Mental Health Act must be based on assessment of the health condition of a specific patient. The explanatory memorandum to amending the Mental Health Act (86SE) states that § 9^1(1) of the Mental Health Act sets out the list of substances and objects that are prohibited in any case whereas, when establishing restrictions mentioned in § 9^1(2) of the Act, a healthcare service provider must proceed from a specific patient on whom restrictions are going to be imposed[10]. For instance, if a patient uses a mobile phone camera to film what is going on at the hospital, their possibility to use a mobile phone may be restricted since their activity significantly endangers the inviolability of private life of persons under treatment (§ 9^1(2) Mental Health Act).

The mobile phone has become an integral part of people's daily life. Therefore, the CPT has considered[11] it good practice to allow patients to use their phones. Situations where restrictions on use of mobile phones are needed should be clearly regulated and explained to patients.

The Chancellor asks that privacy of patients in communicating with next of kin be ensured.

5. Applying and documenting means of restraint

The clinic maintains a general register on application of means of restraint, enabling a quick overview of the frequency and duration of restraint. With regard to each instance of restraint, the requisite form is filled out, and the care and nursing sheet reflects monitoring of the condition of a patient under restraint by nurses and carers. The doctor's assessment of the condition of the

[7] See e.g. the Chancellor's inspection visit of 22–23 October 2020 to the coercive treatment department of the Psychiatric Clinic of Viljandi Hospital Foundation (section 4).
[8] See para. 116.
[9] See p 9; See also the Chancellor's inspection visit of 22–23 October 2020 to the coercive treatment department of the Psychiatric Clinic of Viljandi Hospital Foundation (pp 15–16).
[10] See also the Supreme Court Special Panel order of 18 November 2013, 3-2-4-1-13, para. 8.
[11] The CPT's 2018 visit to Slovakia (para. 134); the CPT's 2020 visit to Finland (para. 106); the CPT's 2021 visit to Sweden (para. 78).

restrained patient and the reasoning for continuing to apply means of restraint is documented with the required frequency.

Applying means of restraint is still documented in handwriting, so that it is sometimes difficult to understand what was written. The Chancellor already drew attention to this problem in the summary of the previous inspection visit.

The documents show that justifying the need for applying – as well as the need for continuing – restraint, including chemical restraint, has improved in the clinic over the years. Doctors' assessments mostly contained descriptions of both the patient's current condition as well as reasoning as to why it was necessary to continue applying means of restraint. As a rule, forms on applying means of restraint included proper notes on chemical restraint along with the names and dosage of the medication used. Nevertheless, a note on chemical restraint was missing in some forms.

One patient had been mechanically restrained a few days before the inspection visit. While under restraint, the patient had sustained skin injuries, but no note to that effect had been recorded on the form on applying means of restraint.[12] A video recording of restraint, documents on restraint as well as interviews with the patient and departmental staff did not raise any suspicions that applying means of restraint might have been unnecessary. A psychiatrist checked the condition of the person under restraint with the required frequency. The patient was given something to drink and food, and their other vital needs were also attended to.

Nevertheless, restraint had not taken place in compliance with requirements.

In restraining the patient who was acting dangerously the medical personnel was assisted by the clinic's security staff. The video recording shows that they mostly only intervened to ensure the security of nurses and carers in restraining the patient. In one instance, however, a member of security staff briefly used apparently unjustified physical force in respect of the mechanically restrained patient. A person whose arms, legs and chest are fixed to the bed can hardly pose a threat to hospital staff in the room, so that use of force was clearly unjustified. And the member of security staff was alone by the patient's bed at that moment. The carer on duty in the same room behind a partition curtain did not prevent or instruct the member of security staff in their actions.

The CPT has repeatedly underlined that use of excessive force in bringing an agitated patient under control is inadmissible.[13] Staff dealing with psychiatric patients must receive the necessary training.[14] In work with patients, security staff may only act under direct instructions by the medical personnel but not at their own discretion.[15]

In the course of restraining, it was necessary that the patient move repeatedly from one bed to another, first and foremost in order to change soiled bedclothes. To relocate the patient, they were released from restraining straps and the straps were replaced with handcuffs which were used to fix the patient's hands either in front or behind them. The patient was handcuffed by a member of security staff.

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[12] The skin injuries sustained in the course of restraint had been recorded in the nurse's records and the doctor's journal but not on the aggregate form on restraint.
[13] See e.g. the CPT's 2017 visit to Cyprus (paras 111–112); the CPT's 2019 visit to Ireland (para. 94); the CPT's 2020 visit to Spain (para. 144); the CPT's 2020 visit to Kosovo (para. 121).
[14] See e.g. the CPT's 2016 visit to Italy (para. 133); the CPT's 2020 visit to Spain (para. 162).
[15] See e.g. the CPT's 2016 visit to Italy (para. 133); the CPT's 2017 visit to Montenegro (para. 108).

According to CPT standards, use of handcuffs to restrain a psychiatric patient is not allowed. After several visits, the CPT has criticised[16] the use of handcuffs in respect of a psychiatric patient both in restraining a patient as well as, for example, during their transport to the hospital[17]. The expert participating in the inspection visit is of the same opinion and holds that the patient in question could have been transferred by using other measures, such as by means of short-term physical restraint (i.e. holding the patient).

The video recording shows that at the beginning of restraint the patient was clothed. After some time, they were relieved of soiled clothes but no new clothes were given. The patient was covered with a blanket but this repeatedly slipped off. Although the staff was in the observation room, the blanket that had fallen off was not always put back quickly enough, so that in the meanwhile the restrained person was not covered with a blanket.

The video recording showed that the patient with soiled clothes was handcuffed and for a few minutes they disappeared – accompanied by security staff – from the view of the camera towards the observation room door behind which the department communal activities room is located. When returning, the patient was naked and still handcuffed. Therefore, a suspicion remains that the handcuffed patient with soiled clothes was taken to a room where they could have been seen by other patients. It may also have happened that other patients saw them naked.

The patient was mechanically restrained, i.e. their arms, legs, chest and shoulders were strapped to the bed. The means of restraint used were adjusted for this purpose but restraint lasted for a long time and the restraining straps inflicted friction wounds on the patient's body. Sustaining the injuries may have been facilitated by the fact that the patient was naked and the straps rubbed against their skin. The video recording shows that the staff attended to the wounds but a plaster that had come off or shifted from the wound was not immediately replaced for a new one. Replacement of at least one wound plaster took over two hours. In a situation where a staff member is constantly present with a patient, such a delay is incomprehensible.

The CPT is of the opinion[18] that means of restraint should be applied with skill and care in order not to endanger the health of the patient or cause pain. According to the CPT standards, a restrained patient must be adequately clothed and it must be ensured that the restrained person is not exposed to other patients. The CPT has said[19] that a patient committed to a seclusion room or restrained mechanically may not be left without clothing.

A healthcare provider has the duty to document injuries inflicted on a patient in the process of restraint. The document form used at the clinic also includes a place designated for describing injuries. With regard to the incident that was investigated, the form contained a note that no health problems caused by restraint had occurred.

The Chancellor has repeatedly emphasised[20] how important it is to document application of means of restraint. The CPT standards require that the register on recourse to means of restraint must

[16] See e.g. the CPT's 2017 visit to Cyprus (para. 126), the CPT's 2020 visit to Moldova (para. 137).
[17] The CPT's 2018 visit to Greece (para. 56).
[18] See para. 48.
[19] See e.g. the CPT's 2014 visit to Austria (para. 132); the CPT's 2016 visit to Portugal (para. 125); the CPT's 2018 visit to Greece (para. 64).
[20] See e.g. the Chancellor's inspection visit of 27 October 2018 to the acute treatment department of Ahtme Hospital; the Chancellor's inspection visit of 9 April 2016 to the Psychiatric Clinic of the South Estonian Hospital; the Chancellor's inspection visit of 29 September 2016 to Wismari Hospital.

contain an account of any injuries sustained by patients or staff in the course of restraint. The CPT has drawn the attention of states[21] to the fact that the relevant register can be used to analyse a hospital's established practice of recourse to means of restraint.

The events occurring in the course of the restraint described above, in combination with insufficient documentation, may be an indication of ill-treatment. The Chancellor asks that, in order to prevent ill-treatment, the clinic should take account of a patient's fundamental rights and CPT standards when having recourse to restraint. Injuries sustained in the course of restraint must be documented and the team must analyse how such consequences could be avoided in the future. No handcuffs may be used in respect of a restrained patient, and a patient may not be left without clothing. No excessive force may be used in respect of a patient and security staff may not restrain a patient without instructions by the medical staff. Medical staff must immediately clean and bandage wounds sustained during restraint.

6. Combating the spread of the SARS-CoV-2 coronavirus and arrangements for treating infected persons

The psychiatric clinic has drawn up guidelines on how to act with a patient suspected of coronavirus infection and a patient with a confirmed infection. Access to treatment does not depend on a person's vaccination status but everyone arriving for treatment is subjected to a rapid coronavirus test. In the third department, a separate ward bloc has been created for placement of patients infected with coronavirus. The same area includes an observation ward where means of restraint can be applied if necessary. During the inspection visit, no one was staying in the department for Covid-infected patients but the clinic maintains constant readiness to also offer psychiatric care to persons infected with the coronavirus.

It is good practice that the clinic staff offer patients information about the coronavirus. Patients can also vaccinate themselves against the disease if they wish. Several unvaccinated patients have made use of the opportunity offered by the clinic.

The CPT has not considered it reasonable to impose a complete ban on visits in social welfare and healthcare institutions. According to the CPT assessment[22], consideration should be given to whether residents could meet with next of kin in safe conditions, establishing requirements for physical distancing and use of personal protective equipment, as well as a temporal restriction.

At the time of the inspection visit, visits to patients were allowed. Each visitor was asked to present a certificate of vaccination or proof of recovery from corona. In exceptional cases, visitors were also allowed to the clinic without the relevant certificate. All visitors were required to wear a mask.

It deserves acknowledgement that the clinic has created the conditions and the staff are prepared to offer psychiatric care even to those infected with the coronavirus. If necessary, patients receive counselling about vaccines and they can also let themselves be vaccinated on site. People have also been enabled to visit next of kin under treatment if reasonable safety requirements are complied with.

I expect feedback to my recommendations from the North Estonia Medical Centre by 4 July 2022 at the latest.

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[21] See e.g. the CPT's 2018 visit to Norway (para. 127); the CPT's 2018 visit to Albania (para. 127), the CPT's 2019 visit to Denmark (para. 181).
[22] See para. 54.

Yours sincerely,

/signed digitally/

Ülle Madise

Copy: Ministry of Social Affairs, the Health Board

Maria Sults 693 8448
Maria.Sults@oiguskantsler.ee