OMBUDSMAN OF THE REPUBLIC OF BULGARIA

ANNUAL REPORT OF THE OMBUDSMAN ACTING AS NATIONAL PREVENTIVE MECHANISM

2024

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HIGHLIGHTS

Pursuant to Article 3 of the Ombudsman Act, for the 12th consecutive year, the Ombudsman institution presents an annual report on its activities as a National Preventive Mechanism (NPM). The functions and powers of the Ombudsman of the Republic of Bulgaria as the National Preventive Mechanism are related to the implementation of the Optional Protocol to the UN Convention against Torture and other Forms of Cruel, Inhuman or Degrading Treatment or Punishment and the amendments to the Ombudsman Act promulgated in the State Gazette, issue 29 of 2012.

The matter of protecting the rights of people with mental illnesses has been particularly acute in recent years. The Ombudsman of the Republic of Bulgaria, in the exercise of its functions as the National Preventive Mechanism, monitors on an annual basis state psychiatric hospitals (SPHs), mental health centres (MHCs) and social facilities for people with mental disorders. In August 2024, the Ombudsman, acting as NPM, carried out an inspection at the psychiatric clinic of the St. Marina University Multi-Profile Hospital for Active Treatment – Varna **on the occasion of another tragic case of a burnt patient while under a temporary measure of physical restraint for immobilisation.**

The inspection found significant violations of the requirements of Regulation No. 1 of 28 June 2005 on the terms and procedure for implementing measures for temporary physical restraint of patients with mental disorders, as well as non-compliance with the instructions of control authorities, the most important of which are:

- **Failure to monitor the patient continuously, as required by the provisions of Article 11 of the Regulation** – pursuant to para 2 of the above-mentioned provision, a patient who is subject to a temporary physical restraint measure shall be monitored **continuously** by the nurses designated by the doctor, who shall change every hour. The nurses monitor the patient by direct visual observation or by remote means during temporary isolation and at the patient's bedside during temporary immobilisation;
- **The failure to register measures of temporary physical restraint** by isolation is a prerequisite for the application of this measure without medical justification and without following the procedure laid down for this, thereby violating patients' rights;
- **The lack of a fire alarm system with central signalling, despite instruction from the control authorities,** is also among the reasons for the late detection of the fire. As early as 2019, the Ombudsman institution alerted the Minister of Health to the need to provide for a requirement to install smoke detectors as a quality criterion for healthcare, in order to improve the safety of patients with mental illnesses.

Alarmingly critical continue to be issues with the provision of social services to vulnerable groups and the lack of control over the implementation of basic standards which create conditions for a threat to the lives of the people in facilities. **In another case of a serious incident of death in an institution that provides social services without having the required license in 2024, the Ombudsman institution immediately reached out to the competent authorities with a proposal to take urgent action to provide for criminal liability of people who provide social services without a license or do not comply with the standards and quality criteria for social services and these actions result in danger to the life and health of people using social services.**

The observations and inspections carried out in 2024 also brought to the fore the issue of the **protection of the rights of asylum seekers in the Republic of Bulgaria** with particular urgency. In view of the strategic geographical position of the country and the fact that the Republic of Bulgaria is an external border of the European Union, the migration pressure in the country has traditionally been increased.

In its work as the NPM, the Ombudsman institution has identified chronic problems which have been repeatedly brought to the attention of the competent authorities, but so far the necessary actions to eliminate them have not yet been taken.

The main shortcomings in the protection of the rights of people seeking international protection, people with temporary protection as well as foreigners who have been refused protection include:

- Poor material and living conditions caused by insufficient funding in the accommodation centres of the SAR with the Council of Ministers and the special centres for temporary accommodation of foreigners (SCTAF) under the Ministry of Interior, taking the form of pests on the premises, high temperatures during the summer months, obsolete and unusable material facilities;
- Deficiencies in medical services due to the shortage of medical specialists, resulting in severely hampered and limited access to medical care;
- Lack of complete and clear information for asylum seekers on their rights and the terms for lawful residence on the territory of the Bulgarian State;
- Lack of a sustainable and long-term state strategy for the support and integration of displaced people which will permanently guarantee their rights of access to social, health and educational services;
- Lack of a well-established practice for foreigners to be informed about the content of individual administrative acts issued against them in a language they know, as well as about their right to contest them in court within the statutory time limit.

In 2024, teams of the Ombudsman institution, acting as National Preventive Mechanism, carried out inspections in the two special centres for temporary accommodation of foreigners under the Ministry of Interior and in five of the accommodation centres for asylum seekers under the State Agency for Refugees (SAR) with the Council of Ministers.

The main focus of each inspection is the assessment of the conditions in which the accommodated people live, the forms of support provided for their integration into the community, as well as the respect of their guaranteed legal rights, the most important of which are:

- **Right to remain on the territory of the country;**
- **Right to social support;**
- **Right to health insurance;**
- **Right to accessible medical care and free use of medical services under the terms and procedure for Bulgarian citizens, and others.**

According to official data from the SAR with the Council of Ministers, the total number of people who applied for protection in 2024 is **12,250**, of whom **56** applicants have been granted

refugee status, **4,895** have been granted humanitarian status, **3,140** have received refusals. The total number of application proceedings is **15,392**, of which **7,301** proceedings were terminated.

The increase in the number of unaccompanied minors in the country remains alarming. According to the statistics of the SAR with the Council of Ministers, for the period 01.01.2024 - 31.12.2024, the total number of applications for protection submitted by unaccompanied minors is **2,601**, of whom **234** are minors, **717** children are aged between 14-15 years, **1,650** children are aged between 16-17 years.

The greatest number of applications comes from citizens of countries with military conflicts such as Syria, Afghanistan, Morocco, Egypt and Iraq.

Significant progress in the protection of the rights of unaccompanied children is the implementation of the recommendation repeatedly made over the years by the Ombudsman institution to establish a safe zone for unaccompanied children seeking protection in the largest registration and reception centre of the SAR with the Council of Ministers in Harmanli.

The zone was launched on 16 May 2024 in the presence of representatives of all stakeholder institutions, including representatives of the Ombudsman. The capacity of the safe zone is **98 places** for accommodation with the option to increase them in the event of a crisis.

Despite the progress made, a number of problems persist, such as problems with the control of **hygiene and sanitation conditions, with access of people to specialised healthcare, with the need to provide better security at the facilities**.

The Ombudsman's recommendation on the need to introduce a systematic policy for the protection and integration of unaccompanied minors continues to be relevant. There is a need to assess possible measures to provide protection and support to unaccompanied persons through their integration into the community. Efforts need to be made to remove children from refugee centres once they have acquired refugee, humanitarian or asylum status in the country and to place them in an appropriate social service in the community.

Another major problem for the children granted status in the country is related to their **obligation to leave the centres where they are accommodated at within 14 days and to declare their address in the municipality where they will settle**. This puts them in a difficult and vulnerable situation because of the obstacles they face in finding an address at which to register. In practice, the Ombudsman has found that registration often poses difficulties for foreigners who have a very short deadline to declare an address and often do not have the necessary documents such as a valid rental contract. As a result, a **mass practice of unauthorised "selling" of address registrations** has been created, in particular Bulgarian citizens allow refugees to register at their address for a fee while the refugees are forced to "buy" address registrations in the country.

In relation to this pressing problem, a proposal was made, within the framework of a working group for amendments to the Civil Registration Act involving the Ombudsman institution, to supplement the Civil Registration Act with a new provision. **The proposal of the**

Ombudsman's experts was to introduce a provision that would regulate the right of people who have obtained status in the country to declare their address in the municipality where they reside in cases where they do not have the legally required documents and have failed to register within the short 14-day period. The proposal was approved and published in the Official Gazette on 8 October 2024, and a new provision of the Civil Registration Act was introduced, Article 93, para 6, which entered into force on 10 December 2024.

Pursuant to Article 39a, para 2 of the Foreigners in the Republic of Bulgaria Act (FRBA), **the Ombudsman is the only state institution that monitors the removal of foreign nationals** subject to coercive administrative measures – return to the country of origin, transit country or third country; and expulsion. In connection with these powers, in 2024 the Ombudsman monitored the implementation of a total of **30 coercive administrative measures of return to the country of origin**. The monitoring teams identified **systematic problems** in the verification of the personal files of foreign nationals, mostly related to the incomplete set of documentation (a foreigner's file):

- Lack of evidence that foreign nationals are familiar with the content of the orders issued with respect to them regarding the imposition of coercive administrative measures, their right to contest them under the Administrative Procedure Code and their right to obtain legal aid;
- Imposing the most severe coercive administrative measure of placement at SCTAF without examining the existing possibilities for a lighter, non-repressive measure under the FRBA.

In relation to the rights of foreigners accommodated forcibly at SCTAF, the Ombudsman, acting as NPM, was contacted at the beginning of the year by a non-governmental organisation which reported the imposition of the coercive administrative measure of forced placement in a special centre for temporary accommodation of foreigners on a citizen of the Islamic Republic of Iran.

It was established that the foreign national had been living in Bulgaria **for 13 years and that his return to Iran would expose him to an imminent risk of torture, inhuman or degrading treatment by the Iranian authorities**. The Iranian national is seeking protection in the Republic of Bulgaria because of a well-founded fear of religious and political persecution in his country of origin.

The inspection team found **that there were no legal grounds to impose the most severe coercive administrative measure on the foreign national**; therefore the Ombudsman turned to the Director of the Migration Directorate at the Ministry of Interior **with a recommendation to issue an order for a lighter precautionary measure and to order the immediate release of the person**.

In response to the recommendation, the Migration Directorate provided information that the foreign national **had been released** from the special centre for temporary accommodation of foreigners, that a protection procedure under the Asylum and Refugee Act had been opened and that the foreign national already **had refugee status and resided legally in the country**.

In 2024, the Ombudsman institution as the NPM carried out a total of **53 inspections** in prisons and prison hostels, in police detention facilities, in state psychiatric hospitals, in refugee accommodation centres and special centres for temporary accommodation of foreigners, in 24-

hour detention facilities with district police departments and in family-type residential centres for children and adults. The number of inspections carried out by categories of inspected facilities is as follows:

Facilities with the Ministry of Justice (prisons, prison hostels, reform schools and police detention facilities) - **22**;

Facilities with the Ministry of Interior - **9** (5 district police departments, Detention Facility – Kapitan Andreevo Village, accommodation premises at Sofia Airport for people not allowed to enter, SCTAF);

Registration and reception centres under the SAR with the Council of Ministers - **5**;

Residential services for children and adults - **14**;

Psychiatric hospitals and mental health centres - **3**.

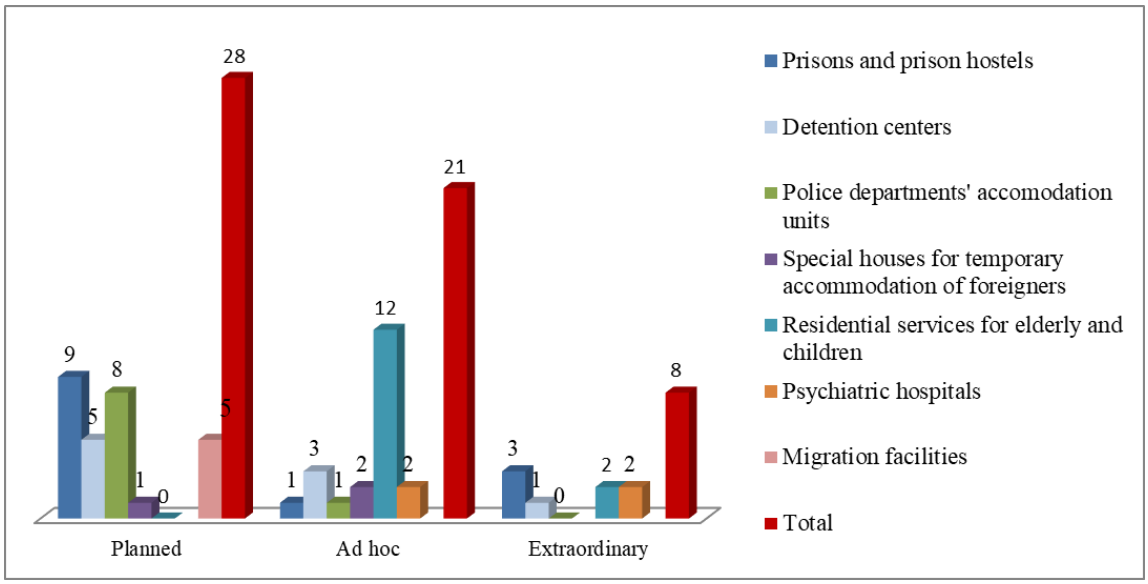

Figure 1: Inspections by type and by categories of sites in 2024.

Source: Statistics of the Ombudsman of the Republic of Bulgaria

In 2024, the trend of a high number of inspections in facilities for deprivation of liberty and detention with the Ministry of Justice continued, with **5** prisons, **7** prison hostels and **8 police detention facilities** inspected. The inspections of places for deprivation of liberty and execution of the measure of remand in custody covered the largest number of people - a total of **1,409** persons deprived of liberty and detainees in the facilities at the time of inspection.

The **main problems of the penitentiary system** identified by inspections carried out over the years remain:

- Poor material and living conditions: limited access to natural daylight, lack of ventilation and air conditioning during the summer months, overcrowding in dormitories, obsolete buildings;

- Difficult access to medical care for persons deprived of liberty and detainees and a shortage of the medicinal products delivered under a contract between the DGEP and a pharmaceutical company;
- Presence of cockroaches, bedbugs and other pests despite ongoing disinfection activities;
- Complaints of ill treatment, violence and uncooperative prison administration;
- Lack of budget funding for social activities due to which the resocialisation and reintegration of the persons deprived of liberty is severely hampered.

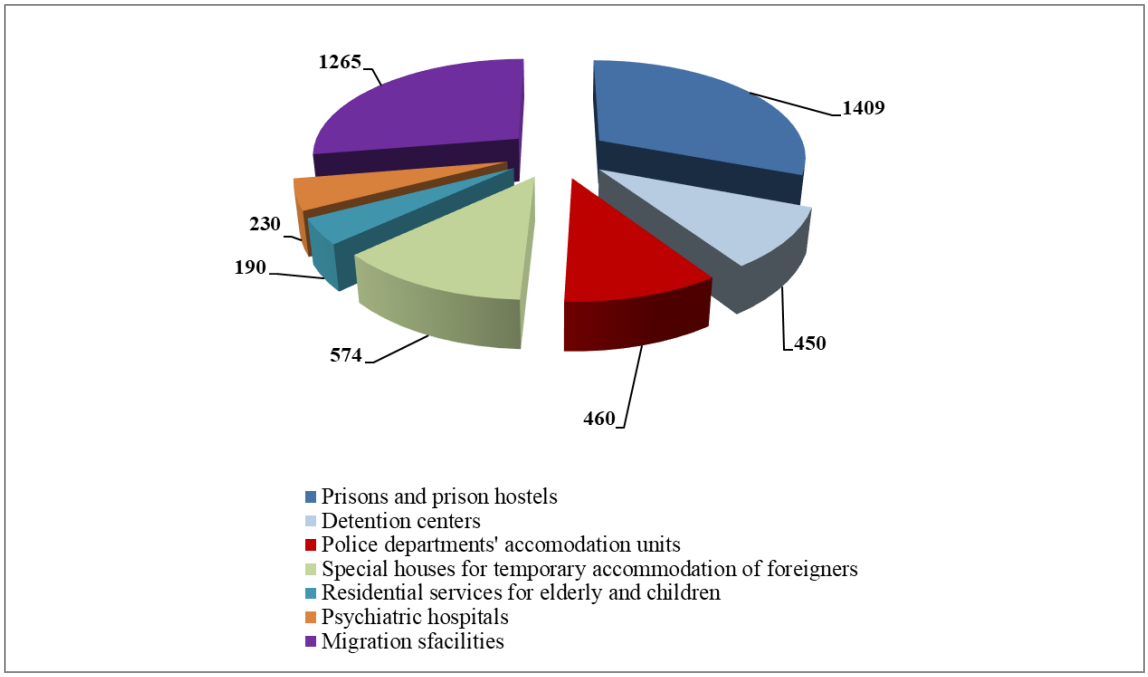

Figure: ***Number of people accommodated in places subject to planned and unplanned NPM inspections in 2024***
Source: Statistics of the Ombudsman of the Republic of Bulgaria

Another highlight of the Ombudsman's work as NPM in 2024 continued to be the protection of the rights of people in the 24-hour detention facilities of the Ministry of Interior. In 2024, teams from the Ombudsman institution carried out inspections in the detention facilities of five district police departments. The material and living conditions in detention facilities continue to be **unsatisfactory, with poor access to natural daylight and obsolete building facilities. The detention premises are in need of major renovation as well as capacity expansion due to the high occupancy rates**.

All inspected facilities have separate premises for the accommodation of minors and the recommendations made by the Ombudsman to comply with the provision of Article 2 of the Child Protection Act when detaining minors are followed. The amendments to Instruction No. 8121h-78 of 24 January 2015 on the procedure for detention, the equipment of detention facilities and the order therein at the Ministry of Interior have implemented the Ombudsman's recommendation on the **mandatory participation of a lawyer when the detainee is a minor.**

In 2024, the Ombudsman as NPM acted *ex officio* **4** times in **cases of police violence**, **suicide attempts and escape from the detention facilities of the Ministry of Interior**, and made recommendations to the Minister of Interior. A particularly disturbing case from the beginning of the year was in connection with a **person detained by officers of the Stara Zagora Regional Police Department who died in custody as a result of excessive use of physical force.** In a letter to the then caretaker Minister of Interior, the Ombudsman emphasised that **the use of physical force and auxiliary means by police officers is a measure of last resort to be applied only when absolutely necessary and insisted on a full, comprehensive and objective investigation of the case. In a reply to the Ombudsman institution, the Ministry of Interior stated that a number of shortcomings and deficiencies had been identified on the part of MoI officers in finding and detaining the person. Two officers were imposed the penalty of dismissal on account of the breaches found in the performance of their duties.**

In the course of all inspections carried out in 2024, the Ombudsman as NPM identified **similar problems and deficiencies in the medical care** at the inspected facilities, which can be summarized as follows:

- **Lack of sufficient number of medical staff**, mostly full-time doctors, which makes it necessary for other medical professionals (lab technicians, nurses) to perform activities not specific to their position such as outpatient examinations and even prescribing treatment;
- **Lack of dental doctors** and limited access to dental treatment in all inspected facilities;
- **Poor material and living conditions** in many of the medical centres and their inpatient facilities which do not meet the requirements for medical institutions and need major renovation;
- **A limited range of medicinal products and consumables** which are procured centrally (on request) in accordance with procurement contracts. If a medicinal product prescribed by an external specialist is missing, it is replaced by an analogous product or a medicinal product with the same effect, and **in the absence of such a product, the residents have to organise its purchase themselves;**
- **Lack of interpreters** which hampers the provision of medical care when the people concerned include foreign nationals;
- **Poor treatment** on the part of medical staff with regard to people detained.

In view of the protection of the rights of all vulnerable groups of people in closed institutions which they cannot leave of their own free will, the Ombudsman of the Republic of Bulgaria is of the opinion that it is imperative ***to improve medical care by taking the following specific measures:***

1) Renew the attempts to attract a sufficient number of medical staff, especially doctors, to the medical centres of the institutions concerned;

2) Discuss ways to increase the attractiveness of medical work, including as regards the work remuneration and other benefits, as well as through individual discussions with doctors in the place or area where the institution is located;

3) Launch an initiative, in cooperation with NHIF and RHIF in the respective region, to ensure that the doctor who is head of the MC is able to carry out the full range of activities for issuing referrals, prescriptions, etc., in order to guarantee the rights of the health insured persons;

4) Discuss, jointly with the Ministry of Health, the possibilities for doctors in all institutions to have the opportunity of continuing training and, in particular, specialisation;

5) Update regularly the list of medicinal products and consumables provided centrally, while taking into account the price increases for a number of medicinal products and consumables;

6) Assess the need to carry out renovation works in medical centres and their inpatient facilities, bringing them in line with the hygiene standards and the requirements for medical facilities, in order to create normal conditions for patients and staff.

MAIN PROBLEMS AND RECOMMENDATIONS BASED ON THE WORK OF THE OMBUDSMAN ACTING AS NPM IN 2024

I. PROTECTION OF PEOPLE WITH MENTAL ILLNESSES

MAIN RECOMMENDATIONS

- *Regular and effective supervision by the Medical Audit Executive Agency of the activities of state psychiatric hospitals, mental health centres and psychiatric clinics;*
- *Take action to instal fire alarm systems with central signalling in all psychiatric structures on the territory of the Republic of Bulgaria;*
- *Reform the state psychiatric care, with an emphasis on patients' rights, especially those in compulsory and coercive treatment;*
- *Review Regulation No. 1 of 28 June 2005 on the terms and procedure for implementing measures for temporary physical restraint of patients with mental disorders and develop a protocol (algorithm) for the application of the coercive measures of immobilisation and isolation, which clearly indicates for how long and how often patients may be isolated and restrained for a period of 24 hours, and specifies the grounds on which these measures are applied;*
- *Streamline the method of financing the different types of psychiatric inpatient treatment facilities linking it to the quality of the health service provided;*
- *Take urgent measures to attract more doctors specialising in Psychiatry and Child Psychiatry;*
- *Prioritise the need to improve the quality of life of patients with mental illness and their socialisation by building appropriate services in the community.*

The Ombudsman of the Republic of Bulgaria, in performance of the functions of a National Preventive Mechanism within the meaning of and in accordance with the Optional Protocol to the UN Convention against Torture and other Forms of Cruel, Inhuman or Degrading Treatment or Punishment adopted on 18.12.2002, monitors annually state psychiatric hospitals (SPH), mental health centres (MHC) and social facilities for people with mental disorders.

Within the meaning of the UN Convention against Torture and other Forms of Cruel, Inhuman or Degrading Treatment or Punishment and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment of the Council of Europe, the state psychiatric hospitals are places of deprivation of liberty as some patients are placed under court orders and cannot voluntarily leave them. This is why, the Ombudsman, as NPM, takes special care to ensure that torture and other forms of inhuman or degrading treatment are not committed in such places.

Unfortunately, the problems identified by the Ombudsman as NPM in the past years are still relevant in 2024.

The amendments proposed to the Health Act, Mental Health Chapter, were discussed at the National Assembly but have not been adopted yet.

Over the years, the Ombudsman as NPM has found that one of the most serious problems in state psychiatric hospitals is the **lack of control by state institutions**. As the Ombudsman has repeatedly pointed out, psychiatric hospitals are funded using the **historical budget** method. This is why SPHs are not inspected by the National Health Insurance Fund, but only by the Medical Audit Executive Agency, mainly when complaints are lodged by patients.

As early as 2012, when the Ombudsman began the work as NPM, the Ombudsman found that the SPHs had never (before the inspections of NPM teams) been audited by the competent authorities regarding their medical activities. This negative finding is one of the main reasons for non-compliance with the requirements of medical standards and for the insufficient volume and type of healthcare provided to patients.

The budget is a key tool for the management of activities in psychiatric hospitals and for respecting patients' rights.

Psychiatric hospitals are funded based on the historical budget method which, in the Ombudsman's opinion, in practice limits the patients' access to quality medical care. Under this budget, there is no direct link between the volume and quality of medical activities performed and the funds received. The financial resources allocated to state psychiatric hospitals are highly insufficient. The so-called historical budget is the reason for both the poor conditions in the hospitals where patients are treated and the marked shortage of medical staff due to the low pay for their work and poor working conditions. The low staffing of the medical and diagnostic process, on the one hand, and the lack of funds for appropriate equipment, furnishings and medicinal products, on the other hand, are factors that severely reduce the quantity and quality of medical care provided to patients.

Furthermore, the main differences in the principles following which the budgets of different types of psychiatric institutions (e.g., SPH and MHC) are formed create tension and confrontation among professionals in the inpatient psychiatric care system, which also impacts on the quality of medical services. The Ombudsman has repeatedly recommended to the Ministry of Health that the method of financing be streamlined for all inpatient healthcare facilities, linking it to the quality of the health service provided.

In this regard, as early as 2020 the Ombudsman prepared and sent an Opinion to the Minister of Health on the Draft Strategy for Mental Health of the Citizens of the Republic of Bulgaria 2020 - 2030 and its Action Plan.

The Ombudsman's Opinion on the Draft Mental Health Strategy recommends that a relocation assessment be performed that is linked to the restructuring of all state psychiatric hospitals. It is also necessary to specify the timing and resources required for the relocation of hospitals, as well as suitable buildings for this. The Ombudsman draws attention to the fact that a number of state psychiatric hospitals do not have good locations, are poorly equipped, understaffed and remote from multi-profile hospitals for active treatment.

Another significant problem is the lack of medical staff. The chronic shortage of psychiatrists is noticeable in all state psychiatric hospitals. There is also a shortage of nurses experienced in mental healthcare. In this regard, the Ombudsman recommended that "...the National Strategy for Mental Health of the Citizens of the Republic of Bulgaria 2020 - 2030 should focus on attracting more doctors specialising in Psychiatry and Child Psychiatry".

In previous inspections, the Ombudsman also recommended to the Ministry of Health to revise the Regulations on the Structure and Operation of Inpatient Psychiatric Care Facilities as regards staffing levels in order to improve the number of staff and ensure equal healthcare for all patients with mental illnesses at SPHs.

According to the Ombudsman, another major problem in the provision of care to people with mental illnesses is the lack of quality psychosocial rehabilitation of people with mental illnesses which should be carried out through a system of services provided by the Ministry of Labour and Social Policy.

The Ombudsman's main recommendation to the Ministry of Health over the years has been precisely to launch an urgent reform in the state psychiatric care sector regarding the protection of patients' rights, especially for people placed in compulsory and coercive treatment.

A major part of the care for people with mental illnesses should be related to improving their quality of life by building social services in the community such as day centres for people with mental disorders and family-type accommodation centres for adults with mental disorders - protected homes.

The Ombudsman has repeatedly recommended to the Ministry of Labour and Social Policy and the Ministry of Health to work to remove this group of patients from their isolation in a hospital environment and to provide them with integrated health and social care in the community.

The government mental health policy should prioritise the need to improve the quality of life through the successful deinstitutionalisation of people with mental illnesses and their socialisation through services in the community.

During inspections, the Ombudsman as NPM found two serious cases of violation of the rights of patients with mental illnesses.

In March 2024, a team of the Ombudsman carried out an inspection at the State Psychiatric Hospital (SPH) – Kardzhali. During the interviews with people placed for compulsory treatment under the Health Act in the First Women's Ward, a woman placed there shared that, after a verbal conflict between her and the chairperson of the Kardzhali District Court on 26.02.2024, she had been detained by the police and subsequently taken to the Kardzhali State Psychiatric Hospital. **At the hospital, she was immediately immobilised without being aggressive towards the patients or the staff.** During the immobilisation, she was pressed on her abdomen, as a result of which she defecated in her underwear and asked to be given a nappy. When asked by the Ombudsman's team how she had been restrained, she replied that her hands had been tied above her head and that both her legs had been tied. According to her, she was tied for two days and nights. During the interview, the other patient corroborated these reports as she had witnessed first-hand what had happened.

The Ombudsman's team reviewed the register of temporary physical restraint measures and the medical history and found that there was no record of immobilisation as regards that patient.

Another disturbing fact is that, after the signing of a statement of informed consent to treatment, the comprehensive forensic psychiatric-psychological examination recorded that "...at this time, the person is still impaired in their basic capacity to express informed consent to treatment." Nonetheless, on admission she had been made to sign a statement of informed consent

to treatment, and she herself stated to the Ombudsman's review team that she had been made to sign it against her will, and that the medication treatment had started from the day of her admission, before the court order for compulsory treatment had come into force. However, the expert discussion of the comprehensive forensic psychiatric-psychological examination recorded that there was a refusal of consent to voluntary treatment. The team did not find a waiver of treatment attached to the history of the illness.

During the interview with the director of the Kardzhali State Psychiatric Hospital, the team asked for information as to whom the said patient had abused physically but he could not name specific individuals. In Protocol No. 253 of the Kardzhali District Court of 18.03.2024, the director of Kardzhali SPH, in the capacity of an expert, notes, "In the beginning when she was admitted at our hospital, given that she was very restless, there was a risk for others, but she was not grossly aggressive towards patients and staff. Due to the psychomotor activity, which was already quite pronounced, this risk was high."

The patient said that she was not familiar with her court judgment and that she was made to sign a voluntary treatment statement when she was admitted to the SPH. Also, she did not know what medication therapy was being administered to her.

The other patient said that, on the date on which she was admitted to the Kardzhali State Psychiatric Hospital, the measure of isolation was imposed on her for a day while this measure was also not recorded in the register of temporary physical restraint measures, nor in her medical history. She also said that she was not familiar with her court judgment and had signed a statement of informed consent to treatment. Her forensic psychiatric evaluation notes that "the examinee is unable to give informed consent to treatment".

Patients claim that they were not taken out into the yard during their entire stay.

The team found that the personal phones of patients are taken away during treatment, where this procedure is not set out in the Regulations on the Structure, Activity and Internal Procedure of the Kardzhali State Psychiatric Hospital. Patients do not have free access to a landline or another telephone.

The Ombudsman as NPM recalls that, in October 2021, the Committee for the Prevention of Torture (CPT) of the Council of Europe made a regular periodic visit to Bulgaria, including a visit to the Kardzhali SPH. The Committee notes that serious concern is caused by the fact that, in the Kardzhali hospital, some patients (including patients on voluntary treatment) provided coherent and credible accounts to the CPT delegation of how they had been placed alone, tied to the bed with 4- or 5-point restraints in isolation rooms for more than 48 hours, with incontinence pads throughout the period in which they had to urinate and defecate, these pads being changed every six hours. Some patients also reported that their hands had been tied above their heads and this caused pain, swelling and numbness in the upper limbs. Such painful interventions are defined as abuse and torture.

Furthermore, the CPT found that due to the lack of constant personal supervision by staff, patients were kept in isolation with no sure way of attracting staff attention, being left to shout in vain from inside the locked room or trying to wave their bound hands at the CCTV camera whose screen is in a distant room where there were often no people; this is clearly unacceptable. Moreover, ward patients can see into the isolation rooms when patients are in them, including when they are mechanically restrained.

With regard to recording restraint measures, as found during previous visits, although restraint of patients is recorded in ward registers with appropriate details, this is done formally and does not reflect reality. Even periods of isolation and mechanical restraint lasting several days are recorded as lasting exactly six hours in the case of isolation and exactly two hours in the case of mechanical restraint (the maximum allowed under Bulgarian legislation). In addition, a number of cases of isolation and mechanical restraint that were clearly described as having occurred, particularly in the Kardzhali SPH, were **not recorded at all**.

The Committee understands that, in exceptional circumstances, patients sometimes need to be isolated or mechanically restrained for longer than is permitted under Bulgarian law for clinical reasons, but the current inaccurate recording of these measures is incompetent at best and illegal at worst.

Similar to the situation observed by the CPT delegations during the 2017 and 2020 visits, the examination of patient records confirms that case reviews by the hospital internal psychiatric committees and by the court are indeed generally conducted every six months. However, patients indicate that they did not receive copies of their psychiatric examination reports, nor copies of the relevant court judgment.

The CPT recommends that the Bulgarian authorities take steps to ensure that the patients concerned receive copies of their psychiatric examination reports, as well as copies of any other court judgments concerning the review of their forensic psychiatric placement. Special efforts need to be made to explain the content of these reports and judgments to the patients and to ensure that they understand them. In addition, the patients concerned need to sign a statement certifying that they have received a copy of their court judgment.

As regards the possibility of contact with the outside world, the CPT notes that the majority of patients (most of them on voluntary treatment) are not allowed to keep their mobile phones and the delegation received many complaints that the access to a phone was very limited, sometimes for months on end, especially in Karlukovo, the acute wards in Kardzhali and the women's acute ward in Lovech. In addition, in the Kardzhali SPH, some patients complained that even when they were allowed to make a phone call, a nurse was present during the call, or listened to it, or even talked to the relatives instead of the patient, who just stood next to her.

The CPT recommends that the Bulgarian authorities ensure that all patients with psychiatric illnesses have access to a telephone or mobile phone every day, unless there are serious security concerns or there is a lawful and reasoned medical prescription based on an individual risk assessment or a court order to refuse access to a telephone. In addition, steps need to be taken to ensure that, in this regard, there are clear, written and accessible policies at ward level in psychiatric hospitals in Bulgaria. Furthermore, all patients need to be able to communicate by telephone in conditions that allow for their privacy, unless there is a reasonable medical order to the contrary for safety or security reasons.

Unfortunately, three years after the CPT findings and recommendations, patients sharing the same problems with the Ombudsman's team: unregulated (physical restraint measures are not recorded in the register of physical restraint measures) immobilisation and isolation of patients; patients are immobilised for days; limited access to contact with the outside world such as regular walks in the yard or access to a telephone; patients are not familiar with their court judgments or their forensic psychiatric evaluations; signing

statements of informed consent to treatment without understanding what they were signing or the use of coercion and threats to get them to sign.

Furthermore, the Ombudsman as NPM found that the patient's right to legal counsel (Article 56 of the Constitution of the Republic of Bulgaria) was violated, and, especially, the right to personal contact between the person represented and their lawyer legal representative was restricted; the exercise of the legal profession and the rights of a lawyer was also prevented, in accordance with Article 134, para 1, proposition 2 of the Constitution and the Bar Act.

From the point of view of the restricted right to personal contact between the person and their lawyer legal representative, there are also indications of a violation of the right to a fair and public hearing by an independent court as per Article 6 of the European Convention for the Protection of Human Rights and Fundamental Freedoms. A question also arises as to a violation of Article 13 of the Convention in respect of the State's obligation to ensure effective domestic remedies and mechanisms for the protection of rights enforceable under the Convention and its Protocols.

After the inspection, the Ombudsman recommended to the Minister of Health to:

- Consider the possibilities and take action to:

- discuss measures to ensure the availability of medical staff to meet the requirements of the Psychiatry Medical Standard and to define levels of competence of hospital structures;

- comply with the requirements of the regulations regarding the spatial structure and the provision of privacy for patients.

- Provide support for the investment projects requested by the Kardzhali SPH, including under the National Recovery and Resilience Plan of the Republic of Bulgaria;
- Send a letter of instruction to the directors of state psychiatric hospitals that lawyers of patients have the right to contact them at any time, either in the form of a personal visit or by telephone.

The Ombudsman also recommended that the Executive Director of the Medical Audit Executive Agency (MEAE) urgently carry out inspections of the facts found and provide the Ombudsman with reports of the inspections.

In response, the MAEA informed the Ombudsman that it had carried out inspections at the Kardzhali SPH in 2021 and in 2023 and sent the reports from those inspections in which no violations had been found.

There are no indications that a new inspection was carried out based on the findings of the 2024 report of the Ombudsman as NPM, where the said report made the following recommendations to the Director of the Kardzhali SPH:

- To take action to ensure the necessary minimum space per patient in accordance with the requirements of Regulation No. 49 of 18 October 2010 on the basic requirements for the organisation, functioning and internal order of the inpatient medical facilities and the homes for medical and social care;
- To record all instances of isolation and immobilisation in line with the requirements of Regulation No. 1 of 28 June 2005 on the terms and procedure for implementing measures for temporary physical restraint of patients with mental disorders;

- To familiarise patients for compulsory and involuntary treatment with their forensic psychiatric evaluations and court judgments;
- To ensure daily walks in the hospital yard for the patients in the first male ward and the first female ward;
- The Regulations on the Structure, Activity and Internal Procedure of the Kardzhali State Psychiatric Hospital need to provide for the right of patients to have a regular access to a telephone.

The response of the Director of the Kardzhali SPH to the Ombudsman notes that the Regulations for the Structure, Activity and Internal Procedure have been updated and there is currently no possibility to reduce the capacity of the hospital.

In August 2024, the Ombudsman institution as NPM carried out an inspection at the psychiatric clinic of the St. Marina University Multi-Profile Hospital for Active Treatment in Varna **in relation to yet another tragic case of a patient burned while under the temporary physical restraint measure of immobilisation.**

The inspection found significant violations of the requirements of Regulation No. 1 of 28 June 2005 on the terms and procedure for implementing measures for temporary physical restraint of patients with mental disorders, as well as non-compliance with the instructions of control authorities, the most significant of which are:

- **Failure to carry out continuous monitoring of a patient, mandatory under the provisions of Article 11 of the Regulation.**

Pursuant to para 2 of the above provision, a patient subject to a temporary physical restraint measure shall be continuously monitored by nurses designated by the doctor who shall change every hour. The nurses shall monitor the patient by direct visual observation or by remote means during temporary isolation and at the patient's bedside during temporary immobilisation;

- **The failure to register temporary physical restraint measures** through isolation is a prerequisite for the application of this measure without medical justification and without following the procedure laid down for this, thereby violating patients' rights;
- **The absence of a fire alarm system with central signalling despite instructions from the control authorities** is also among the reasons for the late detection of the fire.

As early as 2019, the Ombudsman institution alerted the Minister of Health about the need to lay down a requirement to install smoke detectors as a quality criterion for healthcare in order to improve the safety of patients with mental illnesses.

After the inspection, **the Ombudsman institution as NPM recommended to the Minister of Health to**:

- Provide financial resources and take action to install fire alarm systems with central signalling all psychiatric facilities on the territory of the Republic of Bulgaria as soon as possible;
- **Prioritise** the installation of fire alarm systems in separate, isolated and secured rooms to implement temporary physical restraint measures for patients with established

mental disorders who have fallen into a state that poses a direct and immediate danger to their own health or life or to the health or life of others;

- All psychiatric hospitals in the country need to be equipped with fire-resistant mattresses in the premises to implement temporary physical restraint measures;
- Ensure regular and enhanced monitoring for compliance with the requirements of Regulation No. 1 of 28 June 2005 on the terms and procedure for implementing measures for temporary physical restraint of patients with mental disorders ("the Regulation");
- Review the Regulation and develop a protocol (algorithm) for the application of the coercive measures of immobilisation and isolation which clearly indicates for how long and how often patients may be isolated and restrained for a period of 24 hours, and specifies the grounds on which these measures are applied.

The Ombudsman institution received only the opinion of the Medical Audit Executive Agency which notes that an inspection was carried out at St. Marina UMPHAT EAD and ***no evidence of violations was found****.*

Furthermore, the Ombudsman institution recommended to the Executive Director of St. Marina UMPHAT EAD to establish a practice for regular control over the application of the coercive measures of immobilisation and isolation in line with the requirements of Regulation No. 1 of 28 June 2005 on the terms and procedure for implementing measures for temporary physical restraint of patients with mental disorders and the Regulations on the internal work procedures at the First Psychiatric Clinic, and also to equip the rooms for isolating and immobilising patients with permanent video surveillance and, until this recommendation is implemented, all temporary physical restraint measures are to be carried out in the room where video surveillance is currently available or in another suitable room where the patient is under constant and direct observation by a staff member.

II. PROTECTION OF ASYLUM SEEKERS

1. Rights of people seeking international protection

As a National Preventive Mechanism, every year the Ombudsman carries out inspections in the special centres for temporary accommodation of foreigners under the Ministry of Interior and in the registration and reception centres for asylum seekers under the State Agency for Refugees at the Council of Ministers. The subject of each inspection is the material and living conditions in which foreign nationals are accommodated, with particular emphasis on the rights of unaccompanied children.

In addition to the living conditions, strict monitoring is carried out of the rights guaranteed by law to people in international protection proceedings such as: the right to housing, the right to medical care, the right to information, the right to legal aid, etc.

The powers of the Public Advocate include investigation of the impact of amendments to the legislation on the rights of those affected, as well as following up on the actions of the competent state authorities. Where a risk of threat or infringement of fundamental rights and freedoms is identified, binding recommendations are made to the public authorities.

MAIN RECOMMENDATIONS

- *Develop a systematic state policy for the protection and integration of unaccompanied minors granted refugee status, including through their placement in an appropriate social service;*
- *Establish a sustainable policy for informing asylum seekers about the terms for residence in the Republic of Bulgaria;*
- *Elaborate a long-term state strategy for the integration of displaced people to ensure their permanent access to social, health and educational services;*
- *Find a sustainable and long-term solution to ensure sufficient medical staff in refugee accommodation centres.*

In performance of these functions, the Ombudsman monitors the implementation and enforcement of international instruments in Bulgarian law and practice.

For more than a decade, third-country nationals have been crossing the territory of the Republic of Bulgaria while fleeing from armed conflicts, mainly from countries such as Syria, Afghanistan, Morocco, Iraq, Egypt, Libya and others.

According to statistics of the SAR with the Council of Ministers, **from 01.01.2024 to 31.12.2024, 12,250** people sought international protection in our country, of whom **10,652** were male and **1,598** were female. Out of the applications for protection lodged, **56** proceedings were concluded with a positive opinion and, accordingly, the people acquired refugee status, while **4,895** persons acquired humanitarian status. The remaining proceedings were either refused or terminated on one of the legal grounds exhaustively listed in the Asylum and Refugee Act (ARA).

The increase in the number of unaccompanied children continues to be alarming, with **4,021** children applying for international protection in the same period, of whom **2,601** were unaccompanied.

In May 2024, the recommendation repeatedly made by the Ombudsman for the establishment of a safe zone for unaccompanied minors on the territory of the registration and reception centre in Harmanli was implemented. Still, many of the problems identified over the past years remain unresolved. Among the main ones are **the lack of a systematic state policy for the protection and integration of unaccompanied minors.**

A tendency has been identified in the course of the inspections carried out over the years for children granted international protection to permanently settle and stay in refugee accommodation centres due to a shortage of places in social services.

In view of this, all relevant institutions (SAR with the Council of Ministers, SACP, SAA) need to make efforts and assess the possible measures to provide protection and support to unaccompanied persons who have been granted status in the country, through their integration in the community and placement in an appropriate social service or foster families following the model of other European countries.

2. Rights of people with temporary protection in the country

As a result of Russia's military aggression against Ukraine, millions of people have fled the war, seeking asylum in European Union Member States, triggering the existing mechanism **under Directive 2001/55** on minimum standards for giving temporary protection. According to the legal definition contained in **Article 2(a)** of Directive 2001/55, temporary protection is a ***procedure of exceptional character.***

MAIN RECOMMENDATIONS

- *Develop a state strategy for the integration of displaced people with specific measures for access to social, health and educational services;*
- *Align the immunisation calendar of foreign children to that in Bulgaria;*
- *Adapt the educational forms for the inclusion of children receiving international or temporary protection;*
- *Provide psychological assistance to unaccompanied children in need and people arriving from conflict zones;*
- *Provide medicines for patients with chronic illnesses as support therapy until they obtain international or temporary protection status.*

Temporary protection is granted in the event of a mass influx of foreigners who have been forced to leave their country of origin due to armed conflict, civil war, foreign aggression, violations of human rights or large-scale violence on the territory of the country concerned or in a particular region of that country and who are unable to return there for these reasons (**Article 1a, para 3 of the ARA**). Temporary protection is granted by the Council of Ministers in connection with a decision of the Council of the European Union. In view of the ongoing military operations in Ukraine, ***Decision No. 54 of 25 January 2024 of the Council of Ministers*** extended the period of temporary protection until **4 March 2025** and it is expected to be extended for another

year until 4 March 2026. Compliance with the rights of people with temporary protection continues to be a focus of the Ombudsman institution, with a main emphasis on ***their right to housing, the right to access to medical care, the right to social benefits, the right to information and other rights.***

Despite the amendments and supplements to the ARA in order to align our legislation to the European legal acts, certain **gaps and contradictions in the national legal acts in the field of asylum** have been identified. For example, the Temporary Protection Directive provides that **there is no obstacle for a person with temporary protection to apply for international protection**. In this respect, it is established that the Chair of the SAR with the Council of Ministers issued Order *No. RD05-263/08.04.2022* ordering the **suspension of the registration and initiation of international protection proceedings for applications lodged by displaced people from Ukraine**. This means that even if a person enjoying temporary protection lodges an application for international protection, the proceedings will be **terminated**. The order of the Chair of the SAR with the Council of Ministers was appealed in court but upheld by the Supreme Administrative Court and is, therefore, in force. The problem is further aggravated by the fact that, **pursuant to Article 40, para 3 of the ARA, the registration card of people with temporary protection is not equal to an identity document**, which blocks the access of these people to a number of services and generally violates their fundamental rights and freedoms guaranteed by law. Calls have been made in a number of administrative cases to request a preliminary ruling of the Court of Justice of the EU as to whether the national legislation as it stands (ARA) complies with EU law, but so far they have been rejected.

In some EU Member States, beneficiaries of temporary protection may lodge applications and the proceedings are suspended for the duration of the **temporary protection, rather than being terminated**, which does not completely block their path to international protection.

3. Rights of people who have been denied international protection

The Ombudsman of the Republic of Bulgaria is the only Bulgarian state institution monitoring the removal of foreign nationals in accordance with the provisions of Article 39a, para 2 of the Foreigners in the Republic of Bulgaria Act (FRBA).

In 2024, 30 **coercive administrative measures** of return to country of origin, transit country or third country were monitored.

The monitoring teams found the following problems in the check of the personal files of extradited foreign nationals:

MAIN RECOMMENDATIONS

- *Establish a mechanism to control systematically the illegal repulsion of foreigners at the border, including by seconding additional staff;*
- *Approve a standard form of orders for the imposition of coercive administrative measures under the FRBA **to be signed** by the foreign national **and by a sworn translator/interpreter**;*
- *Establish a mechanism for systematic notification of the Ombudsman on pending enforcement of coercive administrative measures under the FRBA;*
- ***Ensure that the files of the foreigners placed in SCTAF contain all relevant documents.***

- The personal files **are not appended with all documents** related to the procedures of imposing and implementing coercive administrative measures under the FRBA;
- There are frequent cases in which orders for the imposition of coercive administrative measures under the FRBA are **not signed by translators/interpreters**, nor is there evidence appended to them that the foreign nationals are familiar with their content and with the statutory possibility to contest them;
- **Lack of evidence that** that the foreign nationals placed in SCTAF are familiar with their right to legal aid and that they have met with lawyers who have consulted them and informed them of their rights and possibilities of defence;
- In the case of proceedings before the State Agency for Refugees with the Council of Ministers for granting international protection, **no evidence is appended** that the relevant proceedings have been terminated or concluded by decisions in force refusing protection;
- Imposing the measure of compulsory placement in a special centre for temporary accommodation of foreigners without examining the case of the foreigner individually and despite the possibility of applying other lighter non-repressive precautionary measures under the FRBA.

In connection with the powers to monitor the implementation of coercive administrative measures under the FRBA, in 2024 the Ombudsman institution became aware of a highly disturbing case concerning the detention of a citizen of the Kingdom of Saudi Arabia in a closed-type room of the SAR with the Council of Ministers, who has been there since 23.11.2021 **for more than three years**.

On 25.05.2022, the Chair of the SAR with the Council of Ministers rejected the person's application for international protection. The foreigner contested both the refusal to be granted protection and his placement in a closed-type accommodation which has been ongoing for years. In this respect, the Ombudsman emphasises that, in accordance with the provisions of Article 9, para 1 of Directive 2013/33/EU of the European Parliament and of the Council laying down standards for the reception of applicants for international protection, ***"...an applicant shall be detained only for as short a period as possible and shall be kept in detention only for as long as the grounds set out in Article 8(3) are applicable (when protection of national security or public order so requires)".***

The above European legal act does not indeed provide for a specific maximum period of detention, but the time during which the Saudi national is detained in a closed-type detention facility certainly cannot be described as a "short period" and amounts in fact to a the punishment of deprivation of liberty without there having been a judicial act and an effective sentence in practice.

The conditions in which the Saudi national is placed are not suitable for such a long stay and can be described as **inhuman and degrading**. Despite the existence of such circumstances, the protection proceedings cannot be concluded due to **omissions of the relevant government authorities**.

In relation to another inspection by an Ombudsman team as a National Preventive Mechanism in the room for people not allowed to enter at Sofia Airport, **another case of excessive**

detention of foreigners was found. At the beginning of October 2024, the Ombudsman institution was made aware of the case of a Syrian citizen who, in September 2024, was placed in the room for foreign nationals not allowed to enter located in the building of Terminal 1, **for a period of 20 days** before being transferred to a centre of the SAR with the Council of Ministers. **Placements in that accommodation are intended to be for as short a period as possible, until the next flight to the person's country of origin.** In that case, the foreigner resided in unfavourable conditions for nearly three weeks.

With regard to the above cases, the Ombudsman institution made recommendations to the competent authorities that the protection proceedings be dealt with within a reasonable timeframe.

In addition to the above circumstances, the monitoring teams identified cases of pending enforcement of coercive administrative measures under the FRBA for which **the relevant notifications were not sent to the Ombudsman within a reasonable time**. For these reasons, there is a de facto impossibility to carry out observations prior to the implementation of the coercive administrative measure imposed.

Isolation facilities

III. PROTECTION OF THE RIGHTS OF CHILDREN AND ADULTS PLACED IN RESIDENTIAL SOCIAL SERVICES

In 2024, the Ombudsman as NPM carried out **ad-hoc inspections in a total of 14 social institutions for children and adults**. Over the years, the Ombudsman has repeatedly recommended that the process of deinstitutionalisation of adult care be accelerated, as the prolonged residence of people with disabilities in institutions violates fundamental human rights and the homes themselves can be defined as places of deprivation of liberty.

Unfortunately, the problems identified by the Ombudsman as NPM in the past years are still relevant in 2024.

In the reports, the Ombudsman as NPM has repeatedly noted the negative finding of an apparent lack of will and vision to move residential care services into the community. Instead, the opposite trend is observed: the facilities of the institutions remains the same, opened at a great distance from the municipal centre and in some cases, without accompanying infrastructure, are refurbished with minimal resources to create protected homes and family-type accommodation centres. This leads to the practice of locating new services in the yard of the respective residential service.

The Ombudsman as NPM reiterates that the Common European Guidelines on the Transition from Institutional to Community-based Care (p. 129) state that **"Plans for the future use of the building should be made as part of the process of closure… it is also important to ensure that no part of the building is used to provide institutional care, for any group of people"**.

MAIN RECOMMENDATIONS

- *Do not launch a new type of social services in the buildings of the old existing services;*
- *Children and adults who are in the process of deinstitutionalisation and are to be removed are to be prepared in advance for their removal;*
- *Teams and medical staff in the places where children and adults will be moved need to become familiar with heir individual needs in advance;*
- *Children and those whose relatives maintain contact with them need to be accommodated as close as possible to their place of residence;*
- *Ensure in-depth communication on the part of the Child Protection Departments of the Social Assistance Directorates with the managers of the residential social services for children;*
- *Perform a full examination of whether all buildings in which social services for children and individuals are provided meet the regulatory requirements, especially in terms of accessible environment;*
- *Take action to ensure further support to teams providing care to residential service users.*

The permanent isolation of people with disabilities further exacerbates their illness. This is a prerequisite for potential difficulties in moving them to new social services and a barrier to their successful future inclusion in society. This is why the opinion of the Ombudsman as NPM is that new residential social services should be opened in the community, close to health and social infrastructure.

It is also essential to ensure an accessible environment in residential social services for children and adults. The Ombudsman has repeatedly

pointed out that, regardless of the profile of the social service, the failure to provide an accessible environment violates the requirements set out in:

- UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;
- UN Convention on the Rights of Persons with Disabilities;
- Persons with Disabilities Act;
- Spatial Development Act;
- Regulation No. RD-02-20-2 of 26 January 2021 for determining accessibility requirements and requirements for universal design of accessible environment elements in urban territories and buildings and facilities.

Furthermore, the lack of accessible environment violates fundamental human rights and the dignity of people with disabilities and runs contrary to Standard 4, Criterion 4.4 on the environment where services are provided (Annex No. 12 to Article 11, para 1 of the Regulation on the quality of social services). The abuse and failure to maintain an accessible environment are deemed to be discriminatory within the meaning of Article 5 of the Protection against Discrimination Act. Individuals and legal entities acting in a discriminatory manner are subject to administrative criminal liability (Article 78 *et seq.* of the Protection against Discrimination Act).

As regards the teams of staff and managers of all social services inspected, the opinion of the Ombudsman team as NPM is that they are well-trained professionals who provide social services of a very good quality and strive to improve the situation and quality of life of the children and adults placed. The Ombudsman as NPM has repeatedly expressed the opinion that the main factor on which the provision of quality social services depends is human resources. Caring for adults and children placed in residential services in the community is a difficult and responsible task, which is the responsibility of the staff who work with them on a daily basis.

The Ombudsman institution notes that the work of the employees in the residential social services is specific, given the extremely serious health condition of the adults and children placed there, for whom the employees are personally responsible. The vacant positions in almost all of the services visited shows that there is a clear need to support the teams, including through training, supervision and, last but not least, an increase in their work remuneration.

IV. PROTECTION OF PEOPLE DETAINED IN DETENTION CENTRES WITH THE MINISTRY OF INTERIOR

MAIN RECOMMENDATIONS

- *Take measures to tackle permanently the problem with bedbugs and cockroaches in places of deprivation of liberty, including through the provision of bedbug repellents in canteens;*
- *Provide financial resources for major renovation of places of deprivation of liberty, including replacement of heating systems;*
- *Continue efforts and seek new opportunities to ensure a longer presence of medical professionals in places of deprivation of liberty;*
- *Establish a procedure for the payment of medicinal products with prison funds in case of a lack of funds in the personal account of the persons deprived of liberty;*
- *Launch an initiative to increase the annual limit and expand the range of medicinal products supplied as per the technical specification (list) in places of deprivation of liberty.*

In 2024, the Ombudsman institutions, in its work as a National Preventive Mechanism, carried out **22 (twenty-two) inspections** in places of deprivation of liberty with the Ministry of Justice, of which **5 prisons** (Pazardzhik Prison, Pleven Prison, Sliven Prison, Stara Zagora Prison and Plovdiv Prison), **7 prison hostels** (5 open-type ones, 2 mixed-type ones), the **Reform Home for Minor Girls** with Sliven Prison and **8 (eight) inspections of police detention facilities** (Elhovo, Haskovo, Svilengrad, Pazardzhik, G.M.Dimitrov (2 inspections), Vekilski, Sliven and Stara Zagora).

The main problems of the penitentiary system continue to be relevant in 2024. Particular attention was paid to the problems related to the unfavourable living conditions in places of deprivation of liberty and places of detention, which create a risk of placing persons deprived of ***liberty and detainees in conditions of torture, ill, degrading and/or cruel treatment***. These include mainly overcrowding and insufficient living space, limited and insufficient access to natural daylight, the presence of pests (cockroaches and bedbugs) in accommodation premises, poor and outdated facilities.

In addition to complaints about poor material and living conditions, a significant number of the signals and complaints received by the Ombudsman concern **poor treatment by the prison administration** and non-compliance with legally guaranteed rights such as: the right to information, the right to counsel in all stages of the process, the right to work, etc. A poor practice has been found, namely that **copies of individual administrative acts** which directly affect the legal sphere of persons deprived of liberty (e.g. orders refusing the transfer of a person deprived of liberty) and which are subject to judicial appeal **are not provided to the persons deprived of liberty to become familiar with them**. The Ombudsman as the NPM finds this to be a gross violation of the guaranteed right to defence of every person deprived of liberty, as the failure to serve the orders of the Director of the DGEP prevents the persons deprived of liberty from appealing against them before the competent court within the deadline.

For yet another year, the **access to medical care** in places of deprivation of liberty **is hampered**. The problem with the **shortage of medical specialists** in all prisons and detention

facilities remains unresolved. The problem has been partially solved by engaging doctors based on service agreements; however, the Ombudsman institution continues to insist on **ensuring and guaranteeing the permanent presence of medical staff** (including psychiatrists) in places of deprivation of liberty. The increase in the number of detainees and persons deprived of liberty suffering from mental health problems as a result of the use of drugs and their analogues is troubling.

Another problem that was identified in 2024 and will continue to be in the Ombudsman's attention is the **insufficient range of medicinal products**, as well as the annual limit in terms of their value, set in the procurement contract concluded by the DGEP with a pharmaceutical company. This makes it necessary for a number of medicines (outside the list as per the contract) to be paid for by the persons deprived of liberty, many of whom are socially disadvantaged. In view of this, the Ombudsman has repeatedly recommended that **an initiative be taken to increase the annual limit and to expand the range of medicinal products supplied as per the technical specification (list) in places of deprivation of liberty**.

Another serious problem identified during the NPM inspections is the **low percentage of persons deprived of liberty who are involved in education and work**, which seriously hampers the reintegration and resocialisation processes. The Ombudsman has repeatedly emphasised the importance of the right to work and education as *basic means of correctional and educational effect*. Article 77, para 1 of the Execution of Punishment and Detention in Custody Act guarantees the right of persons deprived of liberty to suitable work, while Article 41, para 1 of the Criminal Code provides that *work during punishment shall be for the purpose of re-education and professional qualification.*

The low engagement of persons deprived of liberty is the result, on the one hand, of the lack of sufficient incentives and low motivation. On the other hand, there are also administrative obstacles to their inclusion in the educational process due to the fact that a number of persons deprived of liberty appear in the register of the Ministry of Education as having formally completed primary or secondary education.

V. PROTECTION OF PEOPLE IN POLICE DETENTION FACILITIES WITH THE MINISTRY OF INTERIOR

MAIN RECOMMENDATIONS

- *Allocate funds for the major renovation of the 24-hour detention facilities and ensuring their compliance with international and European standards;*
- *Display in a prominent location in the accommodation facilities for detainees an up-to-date list of lawyers on duty and the telephone numbers of the National Legal Aid Office in accordance with the requirements of Instruction No. 8121h-78 of 24 January 2015;*
- *Resort to the use of physical force and auxiliary means only as a last resort when absolutely necessary and in compliance with the statutory rules.*

In 2024, the Ombudsman carried out inspections in the 24-hour detention facilities of **5 (five) police departments** – District Police Department – Pazardzhik, District Police Department – Septemvri, District Police Department – Sliven, First and Second District Police Departments of the Regional MoI Department in Stara Zagora with the system of the Ministry of Interior.

The material and living conditions in detention facilities continue to be unsatisfactory with **poor access to natural daylight and obsolete facilities**. The detention premises need major renovation as well as expansion of their capacity due to the high workload in these sites. An increase was found in the number of foreigners passing through the 24-hour detention facilities, usually in groups of 10 to 15 persons, making it impossible to meet the intended capacity of the detention facilities. Communication with them is also difficult due to the **lack of translators/interpreters**.

Most of the facilities inspected did not have a **list of lawyers on duty and the telephone numbers of the Legal Aid Office** or the available one was outdated, which the Ombudsman institution considers to be a fundamental violation of the rights of detainees who have the right to a lawyer from the moment of their detention.

Strict compliance was found with the provisions related to the detention of minors, with the mandatory participation of a lawyer in accordance with the rules of Instruction No. 8121h-78 of 24 January 2015 on the procedure for detention, the equipment of detention facilities and the order therein at the Ministry of Interior.

An emphasis in the Ombudsman's activities in 2024 was also the series of inspections (acting *ex officio*) in relation to alleged cases of **abuse of authority by MoI staff, excessive use of physical force and auxiliary means, and suicide attempts** committed by detainees in detention facilities. All letters sent to the competent authorities emphasized that, in accordance with the Ministry of Interior Act (MIA), **the use of physical force and auxiliary means by police officers is a measure of last resort, to be applied only when absolutely necessary.**

The use of physical force and auxiliary means needs to take into account the specific situation, the nature of the public order disturbance and the personality of the offender. Police authorities shall use only the force which is absolutely necessary.

When using physical force and auxiliary means, police authorities **shall take all measures to protect the life and health of the people** against whom they are directed. The use of physical force and auxiliary means shall cease immediately after its lawful purpose has been achieved. In the coming year, the Ombudsman institution will continue to ensure respect for the rights of detainees and prevention of police violence.

Cells for accommodating detainees in Haskovo Detention Center