



Metropolitan Court
19.P.24.597/2017/234.



The Metropolitan Court

The applicant:

Validity Foundation (1053 Budapest, Ferenciek tere 2.)

Representative of the applicant:

Dr. Kegye Adél lawyer (2053 Herceghalom, Árvalányhaj u. 20.)

Defendant II:

Directorate General for Social Affairs and Child Protection (1132 Budapest,
Visegrádi utca 49.) Representative of the defendant II:

Balsai Law Office; Administrator: dr. jr. István Balsai, attorney-at-law (1024 Budapest,
Margit körút 15-17.)

Defendant III:

Pest Vármegyei Kormányhivatal (1052 Budapest, Városház utca 7.)

Representative of the defendant III:

Dr. Nándor Neparáczki, Legal Counsel (1052 Budapest, Városház utca 7.)

Defendant IV:

Ministry of Culture and Innovation (1054 Budapest, Szemere u. 6.)

Representative of the defendant IV:

dr. Anita Besenyei, Legal Counsel (1054 Budapest, Szemere u. 6.)

Defendant V. r:

Ministry of Energy (1011 Budapest, Fő u. 44-50.)

Representative of the defendant V. r:

Dr. Máté Mélypataki, M.A. (1011 Budapest, Fő u. 44-50.)

Defendant VI:

Hungarian Maltese Relief Service (1125 Budapest, Szarvas Gábor u. 58-
60.) Representative of the defendant VI:

Szász & Markovics Law Office; Administrator: dr. Barbara Markovics, lawyer (1125
Budapest, Sólyom u. 22. I/4.)

Defendant VII:

Ministry of the Interior (1051 Budapest, József Attila u. 2-
4.) Representative of the defendant VII:

Dr. György Bányai, Legal Counsel (1051 Budapest, József Attila u. 2-4.)

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Defendant VIII:

Prime Minister's Office (1055 Budapest, Kossuth Lajos tér
2-4.) Representative of the defendant VIII:

Balsai Law Office; Administrator: dr. jr. István Balsai, attorney-at-law (1024 Budapest,
Margit körút 15-17.)

Defendant IX:

Ministry of Public Administration and Regional Development (1054 Budapest,
Akadémia u. 3.) Representative of the defendant IX:

Balsai Law Office; Administrator: dr. jr. István Balsai, attorney-at-law (1024 Budapest,
Margit körút 15-17.)

The subject of the lawsuit:

infringement of personality rights

I n t e r n a t i o n

The court finds that the defendant II. as the maintainer of the Pest County Topház Unified Social Institution (hereinafter Topház), which was operating at 2, Munkácsy Mihály u., 2131 Göd, has ceased to exist without legal successor,

the defendant III. as the body authorising the operation of the Tophaus and

defendant IV, as the social policy and social sector manager

violated the right to equal treatment and the human dignity of an unspecified number of disabled persons accommodated in the Tophaus by failing to comply with their legal obligations to control and take action, by maintaining a degrading and humiliating environment in the Tophaus under their control, authorisation or management, and by restricting the personal freedom of disabled persons in a manner that seriously violated their human dignity, in a manner offensive to their dignity, failed to ensure a healthy and humane living environment, failed to ensure their access to education, habilitation and rehabilitation, their participation in cultural life, recreational, leisure and sporting activities, and full care, and to provide them with a level of employment that would maintain and improve their abilities, and failed to ensure their right to health care.

Beyond this limit, the court will dismiss the action.

Orders the claimant to pay within 15 days to the Court of First Instance of the European Communities the amounts due to it by the

The defendants in VIII and IX shall pay within 15 days HUF 30.000.- (thirty thousand) + VAT per person.

The applicant is ordered to pay the defendant in the sixth instance the sum of HUF 900,000.00 (nine hundred thousand HUF) + VAT within 15 days.

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The Court finds that the State shall pay the fee of HUF 36.000.- (thirty-six thousand HUF) incurred due to the personal exemption of the partially aggrieved parties.

An appeal against the judgment may be lodged within 15 days from the date of service of the judgment, addressed to the Metropolitan Court of Appeal, at the present court.

In the event of an appeal before the Metropolitan Court of Appeal, legal representation is mandatory.

Before the expiry of the time limit for appeal, the parties may request that the appeal be heard by the court of appeal out of court.

If the appeal concerns only the amount or the costs of the proceedings, the time-limit for performance or the costs advanced by the State, or if the appeal is against the grounds of the judgment, either party may request that the appeal be heard by the court of appeal.

I n d o c o l a s

- [1] The Topház Unified Social Institution of Pest County was established in 1977 and originally catered exclusively for mentally handicapped, disabled and severely disabled children, but after several extensions and renovations, it also provided care for adults from 1986 onwards, with 220 beds. Its core activity was to provide personal care in the form of long-term residential social care for the elderly, disabled and psychiatric patients, including full nursing care and home help.
- [2] The institution consisted of 4 departments: adult female and male, children's and finally severely disabled, and since 2004 a 10-bed residential home was built in a separate annex. According to the 2016 KSH data on residents, 41 out of 219 people served are autistic, 9 are mentally handicapped, while 169 are severely and multiply disabled. In terms of age, 49 are minors, 109 are adult males and 61 are adult females. Of the elderly, three have limited capacity and all others are incapacitated.
- [3] The Institution has been involved in the replacement of similar social institutions providing care for disabled people with more than 50 places. Between 2015 and 2016, the Social Institution was also subject to an investigation by the Pest County Office of the 2nd Defendant, as the maintaining authority, followed by an investigation by the Commissioner for Fundamental Rights between 2016 and 2017. The violations found as a result were recorded in the report of the Commissioner for Fundamental Rights No AJBH/257/2017 of May 2017.
- [4] The following findings were made during the 2015 comprehensive audit of the Pest County Government Office:
- [5] The report of the inspection, in addition to a number of factual findings, recorded that the plaster of the bathrooms in the main building is damaged, the entire pipe network is awaiting renovation, and the damage and the repair of the wall water leaks from the pipe bursts cannot be completed until the renovation. The water network of the main building is 70 years old. The head of the institution has submitted an application to the maintenance authority to repair the water network. According to the Head of the Institution, they have the possibility to apply for KEOP funding for the external insulation of the building and the replacement of the windows.
- [6] "Care unit B - boys' section, where the 12-18 year olds and the over 40s live in the back of the corridor, with separation by sex and age group. There are 7 5-bedded and 1 4-bedded room. The bathrooms also accommodate disabled and

the plaster is soaked. In several places there are sections of wall that have been dismantled and not repaired for the above reasons.

- [7] It is also recorded that the number of residents in residential care is high. With the exception of the residential home and the development group building, overcrowding is a feature of the institution. The average number of persons accommodated per room is 5-6.
- [8] According to the representative of the maintainer and the head of the institution, the technical and design work submitted for the extension of the operating licence is still on schedule, but the construction had not started on the day of the inspection. The continuous supply of heating and hot water is only partially achieved - when hot water is used, the heating is stopped and vice versa (Castle building and adjacent building).
- [9] Staffing conditions are partly solved, but at the time of the inspection (2015) the institution had 3 fewer development teachers and was missing a half-time doctor. The Professional Regulation 2 and 3 development teachers and one half-time doctor are required, as set out in Annex 3.
- [10] With regard to the enforcement of the rights of the beneficiaries, the representative of the beneficiary did not initiate any action with the maintainer to put an end to the unlawful practice, nor did he notify the competent authorities of any infringement affecting a significant number of beneficiaries. He did, however, make a comment to the director of the institution concerning the care work carried out in the institution and had a request concerning the placement of a resident, a case which was pending at the time of the inspection.
- [11] As regards restraint measures, the following were used on average per year: psychological reassurance: 100 times; restriction of movement: 0 times; drug therapy: 50 times; isolation: 50 times; complex: not typical. The procedures for restrictive measures are set out in an annex to the Rules of Procedure, which do not specify the detailed rules for exercising the right of complaint.
- [12] The representative of the person with the right of care is notified of the restrictions at the next reception hour of the service provider, while according to § 101/A of the Professional Regulation, the head of the institution must inform the legal representative and the representative of the person with the right of care of the restrictions within 48 hours.
- [13] Complaints handling: complaints are typically made orally by the person receiving care, or by their relatives. Complaints mainly concern the state of bathrooms and injuries caused by fights between people. Verbal complaints are recorded if there is evidence of external damage and are written down in the referral form. The institution has a Stakeholder Forum, which meets twice a year and minutes are taken.
- [14] Organisation of meals: the institution provides at least three meals a day, including at least one hot meal, as part of the full-service package. In the case of minors, supplementary meals are provided at least twice a day, for which the institution's own kitchen is HACCP-certified. The kitchen has an authorised capacity of 250 persons. The following dietary catering is provided in the Institution: diabetic, liver, bile, non-ketotic, lactose-free. In addition to the meals, the institution provides regular fluid intake for inpatients.
- [15] Providing clothing, textiles
- [16] Typically, people use their own clothing and textiles, but if they do not have sufficient quantities and quality of clothing, the institution provides it for them. Sports clothing is provided for minors and disabled persons. The repair and cleaning of clothing is regulated in the house rules; there is an in-house laundry and sewing room. The institution provides three changes of bed linen per person, as well as three changes of linen for cleaning and the necessary materials for cleaning, as required, as part of the provision of textiles and to ensure personal hygiene.
- [17] Health care

- [18] The institution does not provide medical care for the number of hours required by law; there is a paediatrician on duty for 4 hours. Adequate medical room is available. Other (specialised) physicians: psychiatrist 1x 5-6 hours per month, neurologist 1x 8 hours per month, paediatric neurologist 1x 8 hours per month, gastroenterologist 1x per month, orthopaedic doctor 1x per month. Medication is administered appropriately. Regular and occasional stock of medicines is available. The regular stock of medicines is drawn up monthly by the institution's doctor and the head of the institution. The medicines and drugs included in the basic medicine stock are provided free of charge to the residents, and there are 1-2 antibiotics per year, which are paid for by the resident. The list of basic medicines is posted in a prominent place. Individual medicine user record sheets are kept with appropriate content, but do not include the information in the header. An event log (handover booklet) is kept per shift, which is not numbered, and is kept separately for day and night shifts.
- [19] Mental health care
- [20] There are 17 people in the institution who deal with mental health care. The professional programme is part of the annual mental health work plan. The educational institutions that are supposed to provide the travelling teachers have been designated, however, pending the assessment, the KLIK has designated 1 teacher. The institution has weekly plans broken down by classes and by individuals. Employment sheets are kept by name. There is a timetable of sessions. The leisure programme plans, typically monthly or yearly, led by the mental health staff of the institution, are varied and individualised. Programmes available at the time of the inspection: religious, cultural and recreational programmes, holidays (e.g. Easter), birthdays, excursions, circus, holidays (from June). Community facilities available to residents: restaurant, garden, staff restaurant for celebrations. Community religious services are provided: Catholic mass once a month, Reformed pastor, Baptist faith teacher visits once a month. Employment organised within the scope of the institution is occupational therapy - work around the house (laundry, cleaning, nappy distribution). A work bonus is given for participation in employment. 4 persons are under non-restrictive guardianship, while the rest are under fully restrictive guardianship.
- [21] Actions to be taken
- [22] The Public Health Department of the Vác District Office of the Pest County Government Office issued a separate decision on the measures to be taken following the inspection, due to the material conditions of the institution.
- [23] The Department of Guardianship and Justice has prescribed the following measures:
- [24] 1. With regard to the material conditions, they requested information from the maintainer on the status of the implementation of the technical plan for the extension of the operating licence, and the detailed schedule for the deficiencies detailed in the material conditions section (e.g. the condition of the bathrooms, the continuous provision of heating and hot water).
- [25] 2. Pursuant to Article 5/A (1) of the Professional Regulation, the Professional Programme should be supplemented with the ways of cooperation with other institutions.
- [26] 3. Pursuant to Section 92/B (1) c) of the Social Act, the approval of the maintenance authority is required.
- [27] 4. Pursuant to Article 5 (2) b) of the Professional Regulation, the House Rules must be supplemented with the scope of programmes and services that go beyond the basic tasks of the institution and the fees for such services.
- [28] 5. Pursuant to Section 20 of the Social Act, the Register must be supplemented with the claim for out-of-schedule care.
- [29] 6. The use of a valid health certificate in accordance with Annex 1, Part I of the Ir. or a hospital discharge report in accordance with § 3 (2) of the Ir. is required for all

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for applicants.

- [30] 7. Use of a valid income declaration in accordance with Annex 1, Part II of the Ir. 8. Use of a valid declaration of assets in accordance with Annex 1, Part III of the Regulation.
- [31] 9. According to Annexes 2 and 3 of the Professional Regulation, 3 development teachers and one part-time doctor are required.
- [32] 10. Annex 4 to Government Decree 29/1993 should be maintained.
- [33] 11. According to § 2 (5) of the Tr., ad hoc fees must be set.
- [34] 12. Pursuant to Article 6(10) of the Professional Regulations, it is necessary to inform employees of the prohibition of maintenance, annuity and inheritance contracts.
- [35] 13. Pursuant to Article 101/A(2) of the Professional Regulation, the restrictive Action Plan should be supplemented with detailed rules on the exercise of the right to complain.
- [36] 14. Pursuant to Article 101/A of the Professional Regulation, the Head of the Institution shall inform the legal representative and the representative of the person entitled to the care of the child of the restriction within 48 hours.
- [37] 15. Annex 9 of the Professional Regulation should be maintained as appropriate.
- [38] According to Article 51 (2) of the professional regulation, a numbered event log (handover booklet) shall be kept in the residential care facility for each shift of changes in the health status of the residents and of major events concerning them.
- [39] The Pest County Branch of the PSCA's Inspection Report I (2015) recorded the following:
- [40] The Director-General of the PSCF ordered an extraordinary audit in connection with my report No AJB-372/20155 to determine whether the deficiencies identified in this area have been remedied in each institution on the basis of my recommendations and whether the management of the clothing of beneficiaries is being carried out in an identifiable manner. The inspection report included the recommendations made in my previous report, numbered in order, and the findings of the inspection for each recommendation. The inspection was carried out on the basis of a thematic approach, by visiting the institution, reviewing relevant documents and recording statements from the head of the institution (delegate).
- [41] 1. The provider of the institution should exercise more care and detail in its inspections of the provider and use assessment criteria and findings relevant to the prevention of torture and other cruel, inhuman or degrading treatment or punishment and to the fulfilment of the obligations under the CRPD. The maintenance has incorporated the aspects recommended by the Commissioner for Fundamental Rights into the monitoring system, carefully examining the implementation of the rights of persons with disabilities and the fulfilment of obligations relevant to prevention.
- [42] 2. institutional documents should not use stigmatising terms for people with intellectual disabilities and psychosocial disabilities, such as debility, imbecility, idiocy and retardation. The institution does not use stigmatising terms. Previously accepted terms are found in some medical documents, it is not feasible to change them.
- [43] 3. The head of the institution and the representative of the person with care rights should enable the person with care rights to have access to appropriate legal and other support in order to initiate the guardianship review procedure. According to the head of the institution, there was no need to initiate the procedure at the initiative of the beneficiary; the beneficiaries are informed of their rights by the representative of the beneficiary's rights.
- [44] 4. The head of the institution should allow the residents to choose with whom they wish to share a room. A protocol should be drawn up to ensure that they are free to exercise this right. On room choice

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do not have a protocol. The requests of the residents are taken into account, and placements are made taking into account mental health, building conditions and community interests.

- [45] 5. When assigning nurses, the head of the institution should pay special attention to the fact that not only one nurse should work in a nursing unit. The institution should always have at least two nurses per care unit.
- [46] 6. The head of the institution should pay more attention to improving the gender balance in the recruitment of nursing staff. 15 male nursing staff are employed in the institution. In view of this, it is possible to assign male nurses to all shifts.
- [47] 7. The head of the institution and the maintainer should find a way to ensure the continuous provision of mental health and supervision for the staff of the institution. Supervision is a costly activity and therefore cannot be organised. The manager ensures the mental hygiene of staff and the prevention of burn-out through case conferences.
- [48] 8. The head of the institution and the maintaining authority shall ensure that the professional staff of the institution have the opportunity to participate in regular and quality training. These training courses shall ensure that professional staff have access to the relevant provisions of the Protocol and the CRPD and acquire practical knowledge of them. Staff shall receive regular internal and external training
- [49] 4 In courses with free credits. The head of the institution attends internal training courses on the importance of caring for the dignity of the person being cared for, and on ways of avoiding degrading treatment.
- [50] 9. The head of the institution and the maintainer of the institution shall enable barrier-free transport in the institution. Accessible transport is provided in the institution.
- [51] 10. The owner and the manager of the institution shall ensure that in the institution there is at least six square metres of living space per person in the living rooms, at least one bath or shower for every ten persons, and toilet facilities for each sex, that there are no more than four persons per living room, and that there is a room for socializing with a floor area of at least twenty square metres per care unit. This should not be achieved by expanding the building, but by steadily reducing the number of people in care and helping them to prepare for independent living by providing community-based services. To this end, a short-term plan should be drawn up for the outplacement of care leavers. The physical conditions in the institution are partially met. Toilets are separated by sex, and it is not always feasible to accommodate up to four people per room. There are a few people in the institution who can be weaned, but no short-term weaning plan.
- [52] 11. In addition to the quality of the food, the head of the institution should take care that the recipients of the food have access to an adequate quantity of food. The quantity and quality of food is adequate. The recipients of the meals make their requests verbally, which the kitchen staff will comply with as far as possible, taking into account the rules.
- [53] 12. The head of the institution shall ensure that, irrespective of the state of health of the person concerned, there is no compulsory "unplated" bathing of all persons, and that, irrespective of the state of health of the person concerned, there is no visual inspection and examination of the intimate parts of the male person by female nursing staff. (Similarly, the visual inspection and examination of the private parts of female patients by male nursing staff should be avoided.) Bathing shall be carried out with due regard for the health and mental state of the patient, his degree of autonomy and with respect for his private parts. A carer and a person assisting the person concerned shall be present in the bathroom at the same time during bathing and resuscitation. The bathroom door is kept closed. A screen is used for bed-washing.
- [54] 13. The head of the institution shall ensure that the toilets are regularly and

effectively clean and disinfect. Cleaning and disinfection is carried out efficiently and according to a cleaning schedule. Cleaning is carried out and checked and documented.

- [55] 14. The head of the institution shall ensure that the persons in care are properly cared for and that they do not smell of urine. Ensure hygiene by cleaning and washing as often as necessary, in accordance with the protocol, to prevent unpleasant odours.
- [56] 15. The head of the institution and the representative of the person entitled to receive care should regularly provide information to care recipients and their legal representatives on the various possibilities of the complaints mechanism. If necessary and requested by the person concerned, the representative of the person concerned or, if he or she is not available, the staff of the institution should assist in formulating, describing and sending the complaint to the addressee. The possibilities to lodge a complaint are known to the beneficiaries from the House Rules. Any complaints they may have are usually made orally and receive a prompt verbal response.
- [57] 16. If the members of the Stakeholder Forum, as well as the relatives of the beneficiaries and the members of the legal representatives of the beneficiaries, are not elected, elections should be held for them (It is advisable to regulate the functioning of the Stakeholder Forum in such a way that both the members and the chairperson have a fixed term of office, thus ensuring the possibility of shaping the will of the electorate in periodic elections). The members shall be elected for a fixed term of five years. The Stakeholder Forum shall function in accordance with its function.
- [58] 17. The head of the institution and the representative of the person entitled to care should draw the attention of the beneficiaries to the possibility of setting up a care home. If there is a demand for the establishment of a care home, they should provide assistance as required. The beneficiaries are regularly informed, but there is no need for a residents' council in the institution.
- [59] The head of the institution and the owner should ensure that as many and as varied a programme as possible is organised for the beneficiaries. Pay attention to the creation of extra-curricular activities and sports facilities. Increase psychotherapy and outdoor therapy opportunities for the residents. Provide computers and free internet access for the residents. Provide psychotherapeutic treatment to care recipients as needed. Computer and internet access provided. Regular sports activities, participation in both in-house and out-of-house activities
- [60] 19. The head of the institution shall ensure that the persons in care can have sex in a context of real intimacy. There should be no queuing for the use of the intimate room, the key to the intimate room should be available without request, and there should be no fixed "intercourse time" before using the intimate room. An intimate room has been set up in the institution and its key is accessible without request.
- [61] 20. The head of the institution shall ensure that the institution's documents include provisions and recommendations on the sexual life of the persons served, contraception, relationships, use of intimate rooms. Both clients and staff of the institution should be informed of this. The institution has a protocol in this respect, contraception is provided, counselling and discussion is possible in private and in small group sessions. Both staff and beneficiaries have been informed of the procedures.
- [62] 21. The head of the institution should ensure that all unmarried couples who have expressed their desire to share a room and who have an emotional connection are also placed in a room with their spouse/partner. Couples living in the institution may be placed in a conjugal room.

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- [63] 22. The head of the institution should take care to ensure that the patients are aware of the medicines they are taking and their side effects. The institution's doctor shall inform the patients about the medicines and their side effects in detail, depending on their mental state.
- [64] 23. The head of the institution shall carry out a review of the restrictive measures policy, taking into account the relevant legislation. Ensure that both the beneficiaries and their legal representatives are familiar with the policy and that the staff of the institution are obliged to be familiar with and comply with it. If the institution "adult trellis beds" are used, their use should be discontinued immediately. There is no adult cot in the institution, some beds have a fold-down side rail to prevent falls from the bed. The institution has a policy which is posted in a place where it can be seen by all. The head of the institution ensures that the staff's knowledge is kept up to date.
- [65] 24. The head of the institution shall ensure that there is no segregation of beneficiaries according to a record sheet containing the same description for each day, usually without any meaningful information. The information sheets on the imposition of restrictive measures must be duly completed without omission and sent to the representative of the person entitled to representation. The institution shall keep the information sheet on restrictive measures in accordance with the legal requirements and shall notify the representative of the person with rights of defence within a time limit (48 hours).
- [66] (25) Denial of a beneficiary's discharge without penalty or justification is an unlawful practice that requires immediate cessation. The institution shall not deprive the beneficiary of his/her leave of absence for punishment or without justification.
- [67] 26. For beneficiaries who wear their own clothes, are their own clothes returned to them after washing and any necessary repairs, or how are they identified?
- [68] Each person in care wears their own clothes, which are differentiated by signs or by the knowledge of the carers. Cleaning and repairing of clothing is done by care group. After washing, the clothing is sorted and returned to the care groups, where the carers place it in the wardrobe of the cared-for according to the markings and their knowledge. Finally, the inspection report set out in the action plan the tasks to be carried out, the deadlines for completion and the monitoring of implementation.
- [69] 2nd inspection of the Pest County Branch of the PACO (2016)
- [70] Location and condition of the building
- [71] It is located on the outskirts of the city, on the main road, in a beautiful natural setting, easily accessible by public transport and car. Parking is provided for those travelling by car. It consists of a central building, a residential home for 10 people and a development house for 12 people. In the central building, the external cladding, windows and heating system have been renovated. The neglected, ageing and worn interior finishes, damaged doors and poor furnishings do not provide a suitable environment for the residents. There was a strong smell of urine in several areas of the institution, suggesting a lack of cleaning. This is particularly true for the "CsaCso" department, which is the most neglected in the institution. The bleakness and modest furnishings of the living quarters here can have a negative impact on the mental well-being of the residents. The bathrooms in the central building are in a poor state of repair. The plumbing system is in a poor state of repair and there is constant leaking. The plaster on the walls is mouldy and mouldy as a result of the leaks. The institution has a large garden, which is well maintained and regularly looked after, providing a suitable venue for outdoor activities and sports. All buildings are barrier-free.
- [72] Material conditions

- [73] The institution does not meet the material conditions laid down in the Professional Regulation. The institution does not meet the material conditions in terms of the number of persons accommodated per room, the floor area of the rooms, the number and size of the common rooms, the number of bathrooms and toilets. Bathrooms are in a very poor state of repair, with wet walls and poor plasterwork in several areas. Four care units have been set up in the institution, providing care for 218 people. The exterior of the building has been renovated and the heating system upgraded, but the interior is in a dilapidated state, with damaged doors and tiling. The building is unkempt and there is a lack of cleaning. The corridors are cluttered with furniture, bags and rubbish. Some residents were lying on beds without sponges, or on sponges smaller than the size of the bed, or even incomplete. Some of the sponges were worn, torn and soiled with urine. According to staff statements, the institution did not have spare sponges. The size, furniture and intimacy of the room designated as an intimate room were inadequate.
- [74] Personal conditions
- [75] Number of staff authorised under the institution's rules of organisation and operation
150 people. During the audit, the institution's establishment plan as at 21 June 2016 was requested, which showed that the institution had 142 employees, of whom 138 were full-time and 4 part-time. Of the 142 staff, 113 were women and 29 men. The statistical headcount less the number of hours worked by part-time staff is 140,25. On the basis of the compulsory staffing standards laid down in Annex 2 to the Professional Regulation (Annex II, Institutional care, point 2, point D, Residential care and point 6 of the Additional Rules), the institution has the statutory professional staffing levels, but 7 nursing staff and 5 development teachers are not employed. In 2015 and 2016, the turnover rate for staff entering and leaving the institution was 24.7% and 24% respectively. Among the reasons for the high turnover, the low wages in the social sector, the health sector and the labour siphoning effects of the Budapest labour market in general are the most notable.
- [76] Scope of care
- [77] The Institution provides care for people with disabilities. According to the Register of Services, the number of persons admitted to the institution is 220. At the time of the inspection, the number of persons in care was 219. The total number of persons cared for is 219. The persons cared for are mentally handicapped, some of them with a multiple disability, the vast majority with a severe disability. Some residents also suffer from psychiatric illness, some of whom are self-harming and dangerous to others.
- [78] These residents are housed in integrated accommodation, so the institution has installed bars on the doorways to the rooms to protect the residents in bed.
- [79] certificate
- [80] At the time of the inspection, the institution was certified until 31 December 2016.
- [81] Complaints handling
- [82] The beneficiaries are informed about the possibility of a complaints mechanism at a residents' meeting.
- [83] The institution does not have a self-government, but there is a Stakeholder Forum.
- [84] Its members are elected for five years. The Forum meets every six months or as required.
- [85] Restrictive measures in practice
- [86] According to the Head of the Institution, no restrictive measures are applied in the Institution, but the audit revealed the continued existence of a number of restrictive measures. In the central building, there are beds with bars and residents' rooms with bars. According to the institution, these bars are installed to protect the residents in bed, as some residents in the institution may be at risk of harm. One resident's body has been secured with a sheet, the reason being that the resident may vomit if he or she moves his or her hands freely. Furthermore, the use of beds which are

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beds with a grid on three sides and the fourth side facing the wall. These beds cannot be left of their own free will by the patients. In several cases, the use of chairs that were not of the right size for the patient's body shape was noticeable. In the opinion of the manager, the use of restraints is always in the best interests of the patients.

[87] Medical care

[88] According to the Professional Regulation, the doctor of the residential social institution provides regular health checks, medical advice, screening, prescription of medicines and referral to specialist health care if necessary. The institution provides medical care through a general paediatrician (employed by the institution as a civil servant, 20 hours a week) and a psychiatrist (on a contract, once a month). No adult general practitioner is involved, despite the fact that most of the patients are no longer children. There is also a surgeon and a neurologist, both employed by the Jávorszky Ödön Hospital in Vác, who are not under contract. The doctors are also available by telephone during the week as required. The permanent inpatients are seen at the bedside by the institution's doctor as often as required, with a status recording once a year. The neurologist visits the institution monthly, and the surgeon, in consultation with the institution's doctor, visits the decubitus⁷ patients as required. Findings based on the Professional documentation record, for example, that the outcome was documented but the follow-up was not documented; signatures on both sheets were incomplete; documentation in the event logbook was not documented; the hospitalisation of a beneficiary was not recorded in the individual logbook. No care plan was prepared for the CAPD⁸ beneficiary. The nursing and care equipment (special beds, chairs, wheelchairs, bathing beds, potty, etc.) is partially available in the institution, but its quality and cleanliness are not satisfactory. The equipment is disinfected with Neomagnol and MT53 surface disinfectant (Neomagnol disinfectant was not requested by the institution in May and August 2016). Disposable incontinence products were provided as needed, however one of the beneficiaries (room B32) was visibly soaked in a diaper on the bed. During the inspection, care recipients with a neglected appearance were encountered. In one room, there were no mattresses on the beds; according to the nursing staff, they were delivered to the laundry. (The transfer of mattresses was not documented either in the care unit or in the laundry.)

[89] ⁷ Decubitus ulcers, also known as bedsores or pressure ulcers, affect elderly and/or disabled people who are permanently bedridden.

[90] In the bathroom of corridor A, a person was undressing unattended, sitting on the floor, the toilet was not flushed, and there was a smell of urine. Several people were "loitering" in the rooms and corridors, a phenomenon that was encountered throughout the morning. Traces (torn newspaper, blanket on the floor) were seen of a service user spending time with bags of used nappies stored by the open door (it was reported that the service user responsible had not removed the bags). After about 45 minutes, the bags were still there. The next day the storage room was also open, the used diaper bags were inside, the blanket was taken away.)

[91] In the room, which was closed off from the corridor and the terrace, three people were unattended; one was lying on the floor, another was sitting on the bed, and a third was standing in the middle of the room. They were able to leave the room, possibly through the bathroom, via another room. Some of the patients were found lying on a much smaller mattress than the bed, also unattended, amusing themselves by swinging a sock. On some terraces, dismantled beds awaiting disposal

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found.

- [92] Storage of soiled nappies is inadequate; the storage room is not locked and bags are not removed on time. After delivery, the bags are stored in open containers in the yard, accessible to the supplied people, until they are removed. The yard is also full of waste, ranging from the aforementioned nappies and waste boards to unusable mattresses awaiting disposal.
- [93] According to the findings of the inspection, the care provided in the institution is inadequate. The comfort of the residents, personal and environmental hygiene and accident prevention are not ensured. It is essential to introduce a model of assisted care. As regards the documentation of nursing and care activities, it can be observed that the documentation of nursing and care activities is not regular: the documentation is typically inaccurately dated and in several cases the signature of the person who carried out the assessment is missing. The logbook is partially numbered and not kept accurately. Signatures on individual care plans are incomplete and the recording and monitoring of care outcomes are typically not done. Monitoring of nursing activities is typically not documented, with missing signatures of the unit manager and the nurse in charge
- [94] Hazardous waste management
- [95] The handling and storage of hazardous waste generated during the provision of care is not in compliance with the law. A separate refrigerator is provided for refrigerated storage beyond 48 hours, adequate temperature is provided in the medicine room, adequate storage boxes are provided but not used. Syringes used in care unit D were stored in the care unit's medicine refrigerator in plastic boxes. (This method of storage is not compliant. Used syringes should be stored in a legally required box for storage, in a separate refrigerator for hazardous waste storage. Hazardous waste generated during the treatment of dialysis patients is not properly stored in the designated bathrooms in open garbage bags. Hazardous waste is stored beyond 30 days, with the last transport prior to the date of the inspection having taken place on 13 June 2016, and the previous transport having taken place in January and April 2016.
- [96] Hand hygiene
- [97] Hand hygiene is extremely neglected throughout the institution, even though the most common way to spread infections is through contaminated hands. The OEK methodological letter on hand hygiene is not fulfilled outside the medical and pharmaceutical room. Wall dispensers are missing, empty or not working. The dispensers used (in some places you have to reach in by hand) are not properly labelled (some labels are from 2014), the type of hand sanitiser used and the time of refilling cannot be identified. Toilets and towels are generally dirty, paper towels are used in few places. Alcohol hand sanitiser is used in care unit C. Hygienic hand washing conditions are not ensured.
- [98] Pharmaceutical care, medication, medical devices, documentation
- [99] According to the Professional Regulation, the institution must ensure the provision of medication, medicines and medical aids to the beneficiaries, as defined by law.
- [100] The use of medicines prescribed for the person receiving the benefit must be recorded using the "Individual Medicines Use Record Sheet", which must be completed at the start of the benefit and then whenever there is a change in the information on the record sheet.
- [101] Medical aids are provided under the public health care scheme. There is no self-medication in the institution. They have a "prescription" procedure Medication orders are registered in the individual diary and in the event diary. A

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medical instructions for medication given over the phone are not always recorded in the logbook. The individual logbook includes the name and dosage of the medicines taken regularly in the cases viewed.

- [102] After prescribing a medicine, the name and dosage of the medicine and the duration of treatment are entered in a so-called medication booklet based on the individual diary. The individual medicines record sheet required by the Professional Regulation is available but is not kept or is not kept with the correct information. The medication record booklet is kept in the lockable medicine room, to which the housekeeper has access, in addition to the nurses administering the medication. The dispensing of the medicine is carried out by a qualified nurse on the basis of the medication booklet. In the ward, medication is dispensed from a medicine dispensing tray. The medicine boxes are dirty. In the institution, weekly medication is given instead of the professionally accepted daily medication. Daily medication dispensing is used on the day of dispensing weekly medication. The medicine dispensing boxes are marked. The person dispensing and dispensing the medication is identifiable. The process of medication administration can be traced from order to administration, however, documentation of medication order or change was not found to be in compliance with legal requirements ("Lack of individual medication record sheet").
- [103] Medicines are dispensed from the original packaging, which is torn off at the edges for easier handling and stored in plastic boxes. Sometimes the tear means that the shelf life of the medicine cannot be determined. In some cases, the original packaging is not replaced, and the paper box (which has an expired expiry date) contains a usable medicine.
- [104] They do not have the necessary equipment and materials for infusion. It is the practice of the institution to provide other beneficiaries with the medicines that are dispensed from the recipient's OTC benefit; if the recipient has exhausted his/her medicines, he/she will not be covered by OTC.
- [105] According to the dispensing nurse, no inventory is kept; the expiry date of the medicines is checked, but at the time of the inspection, there were expired medicines in the medicine cabinet. Refrigerators for storing medicines that require refrigeration are available, per care unit and in the medicine room, but the storage of medicines is inadequate. The temperature of the refrigerators storing medicines was not always adequate, not always measured and documented, and they contained food and expired preparations and used syringes. Expired antibiotic eye drops were found, used as nasal drops (reportedly on doctor's advice, not documented). Daedalon suppository (CsaCso) was found without packaging. Expiry date not established. Stored among kitchen utensils is a supplied weekly medicine box.
- [106] Providing food and hydration
- [107] The institution has a 300-cup kitchen. The kitchen is well equipped. There are five meals a day (three main meals and two small meals), of which at least one hot meal a day. The staff meeting held during the inspection period indicated that the food provided to the care units is sometimes less than sufficient. According to the inspection, margarine is provided in unit B "as a "pre-breakfast" and in Unit D, they found improperly stored sausage fat in the refrigerator, which the caretakers said they were giving as a snack. On the advice of a general practitioner, psychiatrist or specialist, an individualised diet is provided as required. The recipients are given normal, pureed or liquid food.
- [108] The main dishes are pureed in the kitchen. Dessert pureeing in the care units

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is done with a blender, with the right formula. A dietician is provided by the maintenance organisation and a dietician is employed. The necessary fluid intake is ensured, and the patients are offered a drink at least 5 times a day.

[109] Ensuring personal hygiene

[110] The institution has a procedure for ensuring the physical hygiene of the persons in its care. Gender-specific toilets are partially provided. (Provided in a residential home, other care units are not coeducational.) The condition of the bathrooms in the main building is neglected and not regularly cleaned. Soiled bathtubs and bathing trolleys do not allow for proper personal hygiene. Cleaning is not done as often as needed. Clean bed linen and textiles are not properly stored. Routine bathing and washing of hair is supposed to be carried out daily or bi-daily, according to the bathing schedule and the relevant procedures. During bathing and preparation, intimacy in the central building is not ensured. Bed linen is partially provided, and in some rooms the residents are not provided with adequate mattresses and bed linen. Toothbrushes are stored separately per person.

[111] Supply with textiles

[112] The Institution has a laundry, where textiles are cleaned and repaired. The cleaning of clothing is done by care groups. After washing, the carers put the clothes in the lockers. The clothes are "recognised" by the caretakers and sorted. In the laundry, the path of laundry is marked, the path of laundry and clean laundry do not cross if the rules are followed, but among the clean laundry there were uncleaned clothes from donations. If the resident does not have his/her own textiles, the institution will provide him/her with a set of bed linen, clothing, cleaning aids and materials. Safety data sheets are available in the laundry, and washing and drying is carried out in accordance with the instructions of the companies that supply the machines. Incontinence equipment is available and is purchased at the expense of the public health insurance.

[113] Hygiene policy of the institution

[114] The institution has a cleaning policy, which needs to be reviewed. The cleaning process is not documented. The means to carry out disinfectant cleaning are not provided. Two-bucket disinfectant mopping is not used, tools are worn out and dirty. Cleaners do not use the correct colour-coded tools. Cleaning products are not weighed out. The cleaning products used are not identified or are inappropriate. The inspection found that the sanitizer is cleaned with a green-coloured tool for food contact surfaces; the sanitizer, door, shelf are washed with SAFE toilet disinfectant. The cleanliness of the treatment rooms (nurses' rooms) and serving kitchens in the care units is not ensured. Refrigerators are uncleaned, ice, muslins are flying, food waste is not removed from the serving trolleys. Refrigerators for storing medicines contain syringes, food, pencil batteries used along with medicines.

[115] The room for storing dirty nappies is not locked and the removal from the care unit is not ensured in time. Dirty nappies are transported in an open container accessible to the recipient.

[116] Hand disinfection facilities are not provided in the laundry; rubber gloves are reportedly disinfected with alcohol-based hand sanitiser. The rubber gloves are contaminated. The warehouse contains dishwashing and scrubbing detergents with expired expiry dates.

[117] The inspection found that a separate meat preparation machine is used in the kitchen. The temperature of freezers and refrigerators, their control and documentation are partially adequate (not documented at the start of work on the day of the inspection). The warehouse contains expired food. One refrigerator,

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which at the time of the inspection had a temperature of 17 degrees Celsius, contained cleaned boiled eggs, leftover mouldy bread, a plastic bucket with unidentifiable liquid, and a tray with fruit. (The refrigerator was said to have been heated by the warm eggs.) The kitchen was equipped with paper towels and MT 36 hand sanitizer for regular hand washing, and the sink was dirty.

- [118] Food samples are stored at the specified temperature and in the specified bag for 72 hours. The refrigerator used for storage is also used for food storage, and had dill in it at the time of the inspection. Disinfection and cleaning in the establishment is not effective and an infection-free, hygienic environment is not ensured.
- [119] Mental health activity
- [120] According to the Professional Regulation, the care provided in residential care institutions is aimed at restoring and maintaining the physical and mental functions of the person receiving care, which are absent or limited, by providing him/her with individual treatment appropriate to his/her social, physical and mental condition. The residential care institution must do everything possible to maintain and preserve the physical and mental activity of the person receiving care.
- [121] The mental health activities of the institution are managed by the head of the mental health and employment team. The development of the minors living in the institution is carried out by the staff of the KLIK and the Pedagogical Service (one head of the Conduct and two head of the Special Education Service). The KLIK submits an annual special education report on pupils under 16 years of age. Mental health staff work with the minors in the development group, helping them to establish daily routines and habits, while for the under-16s the development plan is drawn up by an external remedial teacher.
- [122] Individualised sessions for people over 18 years of age are provided by the assigned mental health worker. An annual development plan is drawn up by the mental health worker. In the documents consulted, the assessment was mostly 'no change in status, the plan is still valid'. The monitoring of the activity is partially documented, the position and identity of the person who prepares and monitors the activity is not always identified. The development plan for 2015 and 2016 of a freely chosen supplier is literally the same, no progress or obstacle to progress can be identified. Monthly sessions are planned on an employment sheet, prepared in the last week of the month. On the sheet, the mental health worker records the type of activities planned with the beneficiary (games, cooking, mobilisation, story time, ball bath, etc.) In the cases visited, there was no ball bath included in the monthly employment planning, although it is available.
- [123] The patients do therapeutic work in the garden and laundry. Residents help with cleaning and wheelchair mobility. Sports activities (football, outdoor games) are provided to keep the residents physically active. Summer holidays, zoo walks and cultural activities are organised outside the home. Every quarter, a bus "walk" is organised for people who cannot walk. Mental health activities (music, story reading) in the living room only in care unit C (bedridden). Television is provided. Manipulation activities are developed in creative activities. There are about 30 visitors in the institution, family contact is mostly by telephone (those who cannot speak only listen to the relative). Conflict resolution takes place in group sessions, with tension-relieving music and individual sessions. A so-called snoezelen-therapy room is under construction, where music and light effects are used to relieve tension. The daily schedule is designed to allow you to move beyond routine tasks

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outside mental health activities. During their tour of the facility, they met with "loitering" residents throughout the morning. Creative activities were seen on the second day of the inspection. No mental health activities are carried out in the living room. Most of the rooms are bleak and are not decorated in a way that would promote a sense of well-being and the development of the senses. The lack of mental hygiene activities is probably the result of the 'vandalism' of the rooms by the residents, who tear mattresses and pick up floor coverings. This is particularly noticeable in the so-called "CSaCSo" unit. There was an "occupation" of about 15 persons in the dining room; all but 3-4 persons were wandering around aimlessly.

- [124] According to the deputy head nurse, moving out of the living room (even without occupation) is part of the occupation. Rehabilitation activities are not carried out. Monitoring of mental health activities and workshops are ad hoc, unplanned and not documented. Mental health care does not restore and maintain the physical and mental functions that are absent or limited.
- [125] The regularity of keeping records of the value and preservation of the assets of the beneficiaries, the acquisition, use and storage of high-value objects of use purchased for the beneficiaries.
- [126] The assets of the beneficiaries are recorded in an electronic register kept by the Institution on an individual basis. On the basis of a declaration by the head of the institution, the consent of the administrator is required for the purchase of any item of daily use exceeding three times the amount of the allowance claimed by the beneficiary, in accordance with the institution's practice. The manager requests the agreement of the caretaker, and in three of the nine cases examined, he justified the need for the purchase. The administrator's authorisations for the purchase of items above the threshold were obtained on the basis of the documents available. The storage of the assets is carried out by the designated staff member of the institution. In the documentation consulted, there was one case of a caretaker's consent to this. The invoices for the purchase of the items were made out in the name of the beneficiaries. Once purchased, the items are handed over to the recipients via the head of department with a receipt. According to a statement by the head of the institution and the mental health and care staff, the notebooks are kept by the staff member with custody of the person who uses them. The locked away computers in the occupational group are also used by the occupational group together for watching films, listening to music/viewing photos. The thumb drives are used for listening to music, watching films, storing photos and some of them are used to store institutional documents. The storage of USB sticks and cameras is similar to that of notebooks. The kitchen equipment (fridges, coffee machines, sandwich makers, etc.), televisions and music players belonging to the residents are also used by the other residents. All the notebooks and all the items selected at random were found in the institution during the inspection and it was found that the equipment was being used for the purposes of the residents. If the equipment is damaged, it is repaired or, if this is not possible, discarded. One of the recipients owns a mobility machine purchased in 2006 for more than 1 million HUF and a motorised bed purchased for 234,000 HUF. However, the beneficiary was not using a motorised bed at the time of the inspection and it was not possible to establish who was using the bed in question. A mobility device, which the carers said belonged to the beneficiary, is stored in the corridor. It does not have an inventory number, so it is not separate from the institution's inventory (there are several mobile machines in the institution, but without an inventory number it is not possible to identify which machine belongs to whom).

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The blender purchased on 30 April is located in unit B, the recipient lives in unit C, according to the carers. Of the 36 items viewed, an inventory number was found on one item.

[127] Treatment of deceased beneficiaries' valuables

[128] The audit examined the practice of taking inventories of the deceased beneficiaries' valuables and movable property, and the payment of spending money and cash leftovers to the court escrow account. The movable property of a deceased person with a total value of 251 450 HUF was not included in the inventory of the estate. The audit found that the Institution had failed to comply with the provisions of Article 62(1)(d) of the Professional Regulation, which provides that cash found among the deceased's belongings, including cash handed over by the resident for safekeeping and paid into the escrow account, must be paid into the escrow account without delay, but no later than the first working day following the date of death. According to the social worker, it is the practice of the institution to send the list of movable property printed out from the electronic register to the authority as an annex to the inventory of the estate; however, this cannot be clearly established from the institutional documentation.

[129] Enforcement of the rights of beneficiaries

[130] Pursuant to Section 94/E (4) of the Social Act, social institutions are obliged to provide services with full and complete respect for constitutional rights, in particular the right to life, human dignity, physical integrity, physical and mental health. The right to physical and mental health is a constitutional requirement. In addition to the general rights of care, the Social Act lays down specific rules on the rights of persons with disabilities. During the investigation, a number of measures were found to violate the right to care in the Institution.

[131] The beds with bars, as well as the bars on the doors of the rooms and the restraints violate the right to free movement and dignity of the persons in care. The lack of shower curtains and toilet boards in bathrooms violates the right to human dignity. The intimate bathroom in the Institution is equipped but does not fulfil its function. The sofa bed cannot be opened due to the size of the room and there is a hole 4-5 cm in diameter at eye level in the front door.

[132] The right to security is affected by the misplacement of beneficiaries within the Institution. The ground floor is used to accommodate patients who are able to walk, while the first floor is used to accommodate patients with reduced mobility or who are unable to leave their beds independently. In the event of fire, the rescue of residents on the upper floor is not guaranteed. The use of mattresses or beds without bedding is a violation of the right to full care and the right to human dignity and physical and mental health. During the investigation, shocking accommodation was found - some residents slept without mattresses, on metal bars or wooden beds. Some rooms were found to be lacking blankets and pillows. The care staff showed factory-packed blankets, which they claimed were distributed to the residents in the evenings. This is not a realistic solution, and it is likely that the information given does not correspond to practice. Torture and other cruel, inhuman or degrading treatment or punishment did not occur in the institution. No deprivation of liberty is imposed as a punishment or without just cause. The head of the institution has informed us that the right to choose the room of their choice is guaranteed to the residents, taking into account the interests of the residents.

[133] Employee declarations

[134] During the investigation, 5 staff members of the institution were interviewed. From what the staff told us, it can be concluded that the atmosphere in the workplace is tense. Staff are not satisfied with the management of the institution. The institution is understaffed, which makes it impossible to perform certain jobs. It was also noted that in some departments of the institution, professional

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meetings are irregular and infrequent and, overall, managers do not monitor staff. There is a lack of cooperation and coordination between staff, which also affects the care of the beneficiaries. Some staff leave the institution after working 6 hours a day, even though they are paid for 8 hours a day. According to the respondent, this is done with the knowledge and agreement of the managers, but the head of the institution is not aware of this. The staffing levels should be reconsidered, taking into account the qualifications of the staff. According to the Head of Institution, a significant proportion of the staff would need to be reclassified when their illness is determined. It is difficult to fill vacancies, and experience shows that the health sector is a draining force.

[135] 4.6.22. Declarations of beneficiaries

[136] The institution is currently home to 219 people. Based on the interviews with 6 residents on the spot, the following conclusions can be drawn: residents like living in the institution, they like the carers. They often leave the institution, go on excursions and take part in joint activities. The residents are satisfied with the food, but they say that some of the food is not as good as it used to be. One resident complained about worn-out equipment and peeling plaster.

[137] Prior to the interviews, all staff wishing to make a statement were informed that they were not obliged to participate in the interview and that they could express their opinion by leaving their name or surname. Two of the interviewees asked not to be named. A document summarising the interviews and the substance of the statement was produced as a reminder to facilitate the writing of the investigation report.

[138] They like living in the institution, but the people living in the unit called "CsaCso" have reported poor conditions of care. Some of them are receiving occupational therapy rewards for their work.

[139] Summary of the investigation

[140] The inspection found that the institution is partially equipped with the material and staffing conditions to meet the needs of the beneficiaries. The professional work in the institution is sloppy. There are unacceptable violations of the rights of the beneficiaries. The institution gives the impression of being run down and neglected. A hygienic and infection-free environment is not ensured. Mental health activities are not suitable for restoring and maintaining the physical and mental functions that are absent or limited. Care activities are inadequate; the introduction of a supportive care model is essential. The supply of medicines is not provided in accordance with the legal requirements. Expired medicines and foodstuffs cannot be kept and used in the institution, despite the fact that expired medicines and foodstuffs were still found with a two-week gap during the inspection period. There is a lack of cooperation between staff and management, which has a negative impact on the work and the care of residents. Documentation is partially incomplete and does not comply with the legal requirements. Residents consider the institution their home and feel comfortable, but not all are satisfied with the care provided. There is indifference in the workplace and a lack of accurate and clear assignment of tasks and consistent and regular management checks. The management of the institution is inadequate: there is a lack of a caring attitude and a lack of a "care at home" approach. The lack of an appropriate approach, the lack of control and accountability and the inconsistency of monitoring and reporting result in the institution not functioning properly.

[141] 4.6.24. Proposals

[142] The measures and proposals needed to remedy the shortcomings and irregularities found during the inspection and to restore the legal situation:

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- [143] 1. the removal of unjustified restrictive measures for some patients, in particular the use of trellised beds and wooden partitions separating rooms. Replace the current restrictions with alternatives that meet the legal requirements.
- [144] 2. Ending measures that infringe the rights of beneficiaries.
- [145] 3. Repairing damaged doors and interior coverings in the institution, keeping them in good condition.
- [146] 4. Launching the procedure for the preparation of the renovation of the bathrooms, with the assistance of the maintenance contractor.
- [147] 5. Cleaning up chairs, furniture, bags and rubbish in the corridors of the building.
- [148] 6. The liquidation of the mouse droppings contaminated warehouse in the "chalet" building, and the disposal of the items stored there.
- [149] 7. Designing a suitable intimate room.
- [150] 8. to provide rooms of a size and number of persons in accordance with the legal requirements.
- [151] 9. It is recommended to reconsider the accommodation of the care recipients, and to accommodate disabled care recipients on the ground floor.
- [152] 10. Procurement of a sufficient number of bed sponges, provision of spare sponges.
- [153] 11. bed linen and bed linen covers are distributed to all persons served in full, according to the season.
- [154] 12. Provision of protective clothing for employees.
- [155] 13. In addition to the annual leave, it is proposed that the primary means of compensating for the imposition of extraordinary working hours be the granting of time off in lieu. In accordance with the Mt. 143. § (7) provides for the possibility to grant compensatory time off by 31 December of the year following the year in question, thus avoiding an increase in staff expenditure.
- [156] At the same time, they point out that when ordering extraordinary working hours, the provisions of the Labour Code of the Labour Code must be taken into account. 109, and that the granting of time off in lieu for extraordinary work is not permitted as part of annual leave.
- [157] 14. The forwarding of KIRA documents containing certain employer measures for human resources signature and financial countersignature, in accordance with the general procedures, is always required. (Accounting without financial countersignature is illegal. In all cases, the signature of the head of the institution, the imprint of the institutional stamp and the date of signature must be included in the signature.)
- [158] 15. Proper management of documents related to the daily commute to work by private car.
- [159] 16. reviewing the practice of paying the afternoon and shift allowance for all public servants as of 1 September 2012 (In the case of the afternoon allowance, in particular for cleaners, kitchen maids and nurses working 12 hours a day in one shift. Where arrears can be established for the above allowances, they must be made good retrospectively.)
- [160] 17. Posting of information on the amount of the staff meal allowance.
- [161] 18. Completion of medical fitness examinations prior to the establishment of the employment relationship, their completion in case of absence, and placement of the issued certificates in the personal file.
- [162] 19. Carry out a job review of the candidate, taking into account the findings of the first level fitness to practise opinions, which may limit the application. If necessary, prepare an amendment to the appointment or terminate the employment relationship.

- [163] 20. Replacing inspection sheets for personnel materials and obtaining and placing morale certificates in personnel materials.
- [164] 21. In the case of a candidate, obtain additional certificates of previous employment and carry out the necessary verification.
- [165] 22. Completion of the missing competences lists.
- [166] 23. To carry out the abolition of job descriptions for the public servants concerned and update the content of the job descriptions.
- [167] 24. the inclusion of the prohibition of maintenance, annuity and inheritance contracts in all job descriptions or the signature of the declaration of awareness by the persons concerned.
- [168] 25. Keeping regular attendance sheets for all employees on a daily basis.
- [169] 26. Reviewing the classification of all employees, preparing the correct classification and paying the arrears of arrears. In addition, reviewing the periods taken into account for grading, anniversary bonuses and severance pay under Act XXXIII of 1992 on the status of public servants for all staff members of the institution. (In all cases, when drawing up the correct grading and reviewing it, account should be taken of any changes in annual leave.)
- [170] 27. Recording and keeping records of donations.
- [171] 28. to assign a registration number to the regulations in force for ease of reference and monitoring, and to draw up and keep a single register, indicating the number of the instruction, the subject of the regulation, the date of its publication/entry into force and the date of its repeal.
- [172] 29. To carry out the repeal of individual documents, preventing several documents of the same type on the same subject from being in force.
- [173] 30. To review and amend the regulations as soon as possible in order to comply with the legislation in force.
- [174] 31. recording of the statements of the beneficiary and his or her relatives as specified in Article 96 (3) a), c) of the Social Act, at the commencement of the institutional relationship.
- [175] 32. Regular, planned and documented in-process management audits in all departments.
- [176] 33. Continuous filing of institutional documentation.
- [177] 34. To ensure that the measures/instructions/circulars of the Heads of the Institutions are duly issued and to verify the conformity of the legislation referred to therein.
- [178] 35. To set the personal fees in accordance with the applicable legislation and the instructions of the PSCA.
- [179] 36. Taking measures for the recovery of arrears in the payment of personal fees.
- [180] 37. to carry out an inventory of technical equipment purchased for the residents, to assign an inventory number to the technical equipment (currently not separated from the technical equipment of the institution) and to carry out an internal audit on the use of the equipment (who uses the equipment and for what purpose.)
- [181] 38. Reviewing the inventory of the estate of deceased beneficiaries and, if necessary, conducting a substitute probate procedure.
- [182] 39. standardisation of remuneration for work performed by occupational therapy recipients, indication of hours worked and wages on worksheets.
- [183] 40. Obtaining the necessary permits to drive the vehicles used by the institution, keeping the logbooks in accordance with the rules and checking them.
- [184] 41. Registration of donations.
- [185] 42. To conclude a contract of appointment with all doctors providing care in the institution, and to employ an adult general practitioner.

- [186] 43. Ensuring that the stock of essential medicines is in compliance with the law, and posting the list.
- [187] 44. Ensuring the availability of life-saving equipment.
- [188] 45. Carrying out regular inspections of medical devices.
- [189] 46. monitoring of nursing care activities, introduction of regular and planned nursing visits, documentation of the monitoring.
- [190] 47. Maintaining regular and accurate nursing care and medical records, checking documentation.
- [191] 48. Creating missing documentation (adding an individual medication record sheet, numbering the event log).
- [192] 49. Documenting the ordering or changing of medicines in accordance with legal requirements.
- [193] 50. Ensuring a hygienic and infection-free environment: among other things, updating the cleaning policy, adhering to it, and cleaning the institution efficiently and regularly.
- [194] 51. effective and regular cleaning and disinfection of care and nursing equipment.
- [195] 52. Proper storage and disposal of hazardous waste.
- [196] 53. Proper storage of contaminated incontinence equipment.
- [197] 54. Compliance with the OEK methodological letter on hand hygiene, ensuring hygienic hand washing conditions, regular monitoring of implementation.
- [198] 55. The pharmacovigilance time of regular, planned monitoring of the timeliness of medicines, stocktaking of medicines, regular monitoring of implementation.
- [199] 56. Ensuring the physical hygiene of the residents at all times, marking their clothing.
- [200] 57. Accurate documentation of mental health activities, planned and regular monitoring of activities.
- [201] 58. Mental hygiene activity development, of this for this purpose contact with the mental health staff of partner institutions.
- [202] 59. Ensuring, checking, documenting, regularly and efficiently cleaning and maintaining the proper temperature of refrigerators for food and medicine refrigeration.
- [203] 60. Monitoring the expiry date of foodstuffs, discarding expired foodstuffs.
- [204] 61. Updating and accurate maintenance of documents related to the admission procedure.
- [205] 62. The institution is the home of the residents; like home conditions, ensure the most comfortable accommodation, personal cleanliness, cleanliness of the environment, cultural design, good food, occupation Attention should be paid to the increased risk of infection in the community. Activities must be carried out in accordance with the rights of the persons concerned, with their best interests in mind and in accordance with the law.
- [206] The importance of a caring, person-centred approach to care needs to be communicated to all staff in the institution, especially when dealing with a vulnerable population of people with intellectual disabilities who are unable to care for themselves and are self-sufficient. To restore regular operations, the branch will draw up a specific action plan, setting out the tasks to be carried out, deadlines and responsibilities.
- [207] Experience of the Ombudsman's on-the-spot inquiry:
- [208] On 19 January 2017, staff carried out an on-site inspection at the institution. During the Ombudsman's inspection, the head of the institution told his staff that, as indicated in the complaint, a number of violations were indeed taking place at the institution. The building is in a very poor state of repair, it is not accessible and the rooms are overcrowded. In many places there are broken and broken doors, crumbling walls, broken light switches, piping

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The plumbing and sewerage network is also in poor condition, in need of renovation, with leaks and burst pipes almost daily, and traces of the latter can be seen in many places - due to the demolition work required to install the pipelines, there are still huge holes and openings in the walls in many places. In the 1970s, the institution was used as a Children's Home for Health Care, so the rooms are still open-plan, some with 'bathing beds', so that the seriously ill are bathed on the spot in the company of their roommates. Among these rooms, currently used as living quarters, are bathrooms (all separated by a wide glass wall), with 3 to 3 toilets, in rows, most without doors or curtains, almost all toilets without covers. Bathing rooms are also in poor condition, with crumbling plaster and tiles. On the upper floor, one young male patient is secured by his legs to the foot of his bed, and is thus on the floor. He is said to have severe anger outbursts which endanger the physical safety of those around him on many occasions.

- [209] The institution consists of 4 wards: 1 ward for adult male and female patients, 1 ward for minor children and 1 ward for severely disabled persons. There is no district general practitioner providing primary health care. Abuse and aggression between inpatients is commonplace due to the lack of development adapted to individual needs and requirements, and schematic development plans. Care recipients' own clothes are not labelled, so they are dressed on an ad hoc basis. The carers used to organise "turi-butis" for themselves from the donated clothes.
- [210] Pursuant to Article 1(1)(c) of the Decree on the ESCSM, this practice (tethering, securing) constitutes a restrictive measure and must therefore be strictly documented in accordance with the relevant legal provisions, taking into account the maximum duration, rules on monitoring and untying - Article 4(5)(3) of the Decree on the ESCSM, Article 101/A of the Professional Regulation, Article 94/G of the Social Act.
- [211] Several people's teeth are not brushed with their own toothbrushes, but with 2 shared toothbrushes, instead of the toothbrushes and toothbrush cups that are named for each person, which are stored separately and locked away in case of an inspection. In the absence of a retractor, the ball bath is used only by those patients who can enter it independently or with minor assistance.
- [212] Staff saw a young girl with a severe jaw deformity, very neglected oral hygiene and a swollen face, trying to make us aware in a barely visible way that her face was very painful. One recipient was trying to meet her biological needs in the presence of her staff, without any modesty or intimacy, in the 3-tier toilets without curtains or partitions between the single-occupancy rooms.
- [213] A care worker shared her opinion that she would not bring her own autistic child to this institution, but she likes the mentality of the new head of the institution, but has not been working there long enough to make real changes.
- [214] The head of the institution also explained that bathing had previously started at 5 a.m. and was carried out in groups (10-15 people at a time) by stripping the people, placing the people with limited mobility who could not stand on the floor of the bathing rooms and showering them from a distance. Sometimes, when the 1 hectolitre of hot water was used up, some of the people were showered in cold water.
- [215] In the context of the rating of the nursing staff's activities, the head of the institution also noted that in the common rooms, the only difference between the patients and the carers was the use of mobile phones; otherwise, the patients were locked in their rooms and stayed there all day. Health care and schooling are provided in Vác, specialist care in Dunakeszi.

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- [216] He also stressed - as several staff members brought to his attention - that not all members of the nursing staff agreed with the complaints and petitions against him. He said that there were also very well trained nursing staff in the institution, but that there was a need for training against burn-out.
- [217] The head of the institution provided the inspection report of the last inspection by the maintenance inspectorate, which was closed on 28 October 2016, the minutes of the official inspection of 2015, the organisational and operational rules of the institution, the professional programme, the house rules and the protocol of restrictive measures.
- [218] Overall, the Ombudsman and the investigation reports concluded, inter alia, as set out in report AJBH/257/2017:
- [219] - "The rights of beneficiaries are being violated to an unacceptable extent. The institution has a feeling of neglect" (Ombudsman's report, p. 30)
- [220] - "The infection-free and hygienic environment is partially ensured." (Ombudsman's report, p. 30)
- [221] - "Care activities are not adequate." (Ombudsman's report, p. 30)
- [222] - "(...) in the years preceding the change of manager, the institution had already developed neglectful nursing, care and housing conditions that seriously violated the fundamental rights of the persons served." (Ombudsman's report, p. 30)
- [223] - "the replacement of the institutional places in the Topház institution in Göd is an urgent and urgent task for the people concerned, because the chance of a human life for disabled people living in such a conflictual, frustrated and empty atmosphere due to the lack of staff and material conditions has been delayed for years, as the inspection reports have revealed." (Ombudsman's report, p. 30).
- [224] - "In the institution under review, the large number of residential institutions is also noticeable "specificities" such as the extremely high number of staff (218), the lack of facilities (bathrooms, toilets, beds, mattresses) and staff (nursing staff), the lack of accessibility (equal access). All these factors force the staff of the institution to resort to forced solutions (group bathing, beds with bars, door bars) and lead to a sharp drop in the professional quality of care. All these circumstances constitute a serious breach of the fundamental rights of the persons concerned and constitute an abuse of the right to human dignity of all persons equally, of the requirement of equal treatment, of the State's duty to provide special protection to persons with disabilities, and, taken as a whole and in isolation, constitute a violation of the prohibition of degrading and inhuman treatment, which is not in conformity with the international obligations deriving from Article 4 of the CRPD (Ombudsman's report, p. 30).
- [225] - "the official controls of government agencies are often mainly focused on the examination of documentation and the compliance of the documentation system with the legal requirements" (Ombudsman's report, p. 31)
- [226] - "Also, the implementation and monitoring of the 62 proposals made as a result of the reservations inquiry is at what stage." (Ombudsman's report, p. 31)
- [227] Subsequently, Respondent IV ordered an extraordinary investigation and a detailed action plan, while Respondent II recalled the head of the institution.
- [228] The applicant's special needs teacher and human rights lawyer visited the Topház Unified Social Institution of Pest County on a total of 5 occasions (15 and 17 February and 27 February 2017; 9 March and 18 April 2017). The purpose of their initial visit was to find one or more

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a minor who can give an account of what life is like in a large closed institution such as Tophaus through his or her own experiences.

- [229] During the visit of 18 April, out of the 5 visits, the applicant's staff visited practically the entire institution, took written notes of what they observed and at the same time took photographs. They did so because it had already become clear to them, following the first visit, that the persons cared for at the Topház Unified Social Institution of Pest County were subject to serious violations.
- [230] The applicant prepared a report on the situation at the Topház Unified Social Institution of Pest County, in which it summarised the infringements at the expense of the residents of the institution and published a number of photographs, edited in such a way as to exclude the persons concerned from recognition, which support the serious findings of its report.
- [231] The applicant has filed a criminal complaint for the infringements it has discovered and the investigation is ongoing.
- [232] On 30 May 2017, following the extraordinary investigation ordered by Respondent IV, Respondent IV prepared an action plan to remedy the deficiencies and violations identified by the investigation.
- [233] The Pest County Topház Unified Social Institution, defendant I, was dissolved without legal succession during the pendency of the lawsuit, and defendant VI continues its activities in the social institution called Gondviselés Háza Fakapile Emberek Otthona (House of Care for Disabled People).
- [234] The expert opinion of the Eötvös Loránd University Bárczi Gusztáv Faculty of Special Education and Dr. Brigitta Baran, forensic psychiatrist, obtained in the lawsuit, concluded that the investigation of the Hungarian Maltese Charity House of Charity, the personal visit to the institution and the documentation examined showed that the restrictive measures applied in the institution and their documentation were lawful according to the provisions of the law 1/2000.(1/2000) of the Ministry of Social Affairs and Labour in the manner prescribed by law in the data sheet and the insert sheet pursuant to § 101/A (3) of the Decree of the Ministry of Social Affairs and Labour. Furthermore, that the neurological and mental psychiatric health care of disabled persons accommodated in the House of Care is currently provided in accordance with the rules of the profession, modern therapeutic protocols, approaches and legislation, and is documented in accordance with the practice and documentation. Child and adolescent psychiatric care and adult psychiatric care are also reassuring and continuously available with a modern approach. Specialist services, as deemed necessary by the institution's doctors and specialist nurses, are readily available. The institution employs 1 child and 1 adult doctor on a part-time basis, whose flexible office hours and unscheduled availability ensure that no resident is left unattended. A more accurate assessment of the physical status of residents (paediatric, dermatological, gynaecological, dental).
- [235] However, the expert opinion states that access to and implementation of routine screening is a problem, and the domestic health care system is not sufficiently prepared/planned to provide the large number of people with special needs in the procedural area with non-discriminatory and routine access to care outside the urgent care setting. However, steps are being taken to improve this and to address screening, and the institution has contacted the Semmelweis University Dental Care Centre, which is starting to operate as part of the network for dental care for people with autism. The concrete implementation of the screening and care of residents has been hampered by the Covid epidemic.
- [236] The expert opinion also points out that, on the basis of current experience in the institution, there is no overall indication that the medical care available on site is inadequate with regard to the physical and mental condition and needs of the disabled persons accommodated in the House of Care, and that this would require the immediate involvement of an external doctor.

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needed. However, the problem of access to health screening appears to need support to solve it.

- [237] As for the special needs teachers and development specialists, the complex needs assessment related to TL was carried out for all residents, and the experts were given insight into this as well. However, the needs cannot be adequately met in the absence of properly trained professionals. In the field of public education, the school district responsible for the provision of remedial education for pupils in the TL does not provide adequate human resources. In the case of adult residents, although staffing levels are in line with the legislation, the lack of qualified staff does not ensure that human resources are available to respond to needs in a relevant way and are trained in theory and practice. The MMS and the institutions it supports are making great efforts to ensure that they have the best possible staff to meet the needs that arise.
- [238] The expert opinion also pointed out that both the legal representative and the legal representative provided with information on the application of the restrictive measures. As regards the monitoring of the restrictive measures and the maximum duration and lifting of the measures, the rules of the institution contain detailed procedures in accordance with the law, which are thoroughly familiarised by the care staff in the framework of repeated training and followed in practice. There have been no complaints about the use of restrictive measures in the institution since 2017.
- [239] Taking into account the extensive proactive and preventive measures and the internal rules, regulations and compliance with the provisions of the CRPD, as well as the operating principles of the institution and the institutional culture following the change of maintenance, it can be summarised that the legal protection of the persons using the services of the House of Care is ensured. The relationship with the IJS representative for the care of the elderly, who operates within the framework of the legislation in force in the home and the budgetary resources, is intensive and is also meaningful on the part of the residents. When a need for legal assistance arises, residents who communicate well verbally receive appropriate guidance and representation appropriate to their case. In other cases, the so-called "institutional monitoring" carried out by the Ombudsman is of real help, as correspondence between the Ombudsman and the head of the institution testifies.
- [240] Equal access to legal aid, based on the quality and quantity of legal aid to be provided by the state as required by the CRPD, needs to be further developed.
- [241] Overall, the House of Caring operates in accordance with national sectoral legislation to promote and protect the human rights of all persons with disabilities, including residents with special needs. This is also reflected in the Professional Programme of the House of Care - Home for People with Disabilities (Hungarian Maltese Charity Service) approved on 27 August 2018, and the principles set out therein, as well as the organisational culture that is developing along these lines. The management of the institution strives to help the residents to live as self-sufficiently as possible, taking into account the degree of disability, which means planned personal development and assistance in making individual and community decisions based on specific needs.
- [242] Considering that any culture change is a process of employee attitude formation, but also the development of independence for the residents who have been living here for decades is a time-consuming, step-by-step process, the management of the institution should aim to achieve independence at a pace and to a degree that is appropriate to the age, condition and disability of the individual

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as a goal to be achieved in self-care and living.

- [243] The staff surveys that provide feedback on the attitudes and attitudes of the staff towards people with disabilities are part of the IFKT. It shows the gaps in staff knowledge of basic concepts of community inclusion at the time of the transition, the ways and channels of communication, and the support they need to work to a higher standard.
- [244] The increased need for regular case discussions and the indispensability of mentoring and supervision is clear. Staff in the institution have a strong need for professional dialogue and are open to new knowledge and training. Despite this, there was a high turnover of staff following the change of management: those who could not or did not want to go along with the new management and the change of approach and professional direction they had brought about, as set out in the CRPD, left their previous jobs.
- [245] It is clear from the above that not only the service users and the management, but also the staff community have come a long way - attitudinally and culturally - over the past 3 years, and this multifaceted development is not yet over. From a paternalistic institutional culture of decades ago, they are striving to move to a world of human rights for persons with disabilities, enshrined in the human rights catalogue, where human dignity, equality before the law and the autonomy of adults are fully respected, and where they can receive the support and assistance they need to achieve this.
- [246] The court found the above facts based on the contents of the attached and presented documents, the obtained combined expert opinion, the testimony of the legal representative Steven Alen, Kristóf Környei and Mária Herczog.
- [247] In its amended application, the plaintiff requested the court to declare, pursuant to Section 84(1)(a) of Act IV of 1959 (Act on Civil Procedure), that defendant II. r., as the defendant that ceased to exist without legal successor between 27 January 2004 and 30 June 2018, with its registered office at 2, Munkácsy Mihály u. Pest Megyei Topház Egyesített Szociális Intitutions (hereinafter referred to as Topház), operating under the provisions of Article 92/B (1) (b) and (d) of Act III of 1993 on Social Administration and Social Benefits (Social Act), Article 3 (1) (n) and Article 4 of Government Decree 316/2012 (XI. 13.) on the Directorate General for Social Affairs and Child Protection (hereinafter referred to as the Social Act), Article 3 (1) (n) and Article 4 (1) (d) of the Social Act. (4)(a), and by failing to comply with its obligation to monitor the provisions of Articles 41-43 of EMMI Instruction No 13/2017 (31.III.) of 31.03.2017 on the Organisational and Operational Rules of the Directorate-General for Social Affairs and Child Protection, and thus also infringed the right to equal treatment of a number of persons with disabilities accommodated in the Tophaus, and the provisions of the Equal Treatment and Promotion of Equal Opportunities Act of 2003. CXXV of 2003 (hereinafter referred to as Ebktv), there was an imminent risk that you would violate the right to equal treatment of the disabled person accommodated in the Tophaus, thereby implementing Section 10 (1) (harassment) and Section 8 (g) (direct discrimination) of the Ebktv as follows:
- [248] By its failure to act as set out in paragraph 1) above, the defendant II.r. maintained or was in imminent danger of maintaining a degrading and humiliating environment contrary to Section 10(1) of the Act on the Rights of Persons with Disabilities, or in general to Section 8(g) of the Act on the Rights of Persons with Disabilities and Article 15 of the Convention on the Rights of Persons with Disabilities (hereinafter referred to as the Convention on the Rights of Persons with Disabilities) promulgated by Act XCII of 2007, or of causing direct disadvantage

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discriminated against an unspecified number of disabled persons accommodated in the Tophaus by severely restricting the personal freedom of disabled persons in a manner that seriously undermined their human dignity, in breach of Article 14 of the Convention.

[249] organise the cleaning of the persons concerned in a way that is offensive to human dignity and in particular to the dignity of the persons concerned;

[250] It does not provide a healthy, decent living environment for people with disabilities.

[251] The defendant II. by its failure to act as set out in point 1) has maintained and thereby infringed Section 8 of the Ebktv.

by failing to ensure access to education, habilitation and rehabilitation, participation in cultural life, recreation, leisure and sports activities for an unspecified number of disabled adults, contrary to Article g) and Articles 24, 26 and 30 of the Convention on the Rights of Persons with Disabilities, and Articles 67 and 70 of the Social Act.

(3), the provision of comprehensive care, continuing and skill-developing employment, and sports and leisure activities.

[252] The defendant II. r. by its failure to act as set out in point 1) has maintained and, in accordance with § 20 of the Ebktv.

(1) (c), there was an imminent risk that it had thereby infringed the right to equal treatment of an unspecified number of disabled children by directly discriminating against them in breach of Article 8(g) of the Equal Treatment Act by failing to provide them with the equal treatment guaranteed by the 1991. The failure to ensure that the provisions of Article 3 of the Convention on the Rights of the Child (hereinafter referred to as the Convention on the Rights of the Child), promulgated by Act LXIV of 1991, and Articles 7 and 24 of the Convention on the Rights of Persons with Disabilities, were complied with, in particular the provisions of the Social Law.

early development and care under § 70(2).

[253] The defendant II. r. by its failure to act as set out in point 1) has maintained and, in accordance with § 20 of the Ebktv.

(1)(c), there was an imminent risk that it had violated the right to equal treatment of an unspecified number of disabled children by failing to ensure the equal treatment of children with disabilities in violation of Section 46 of Act CXC of 2011 on National Public Education (hereinafter Nkt.), Article 8(g) of the Ebktv.

(3)(a) of this Regulation to education according to their ability.

[254] The defendant II. r. by its failure to act as set out in point 1) has maintained and, in accordance with Section 20.

(1) (c), there was an imminent risk that it had thereby violated the right to equal treatment of an unspecified number of disabled persons by failing to ensure their right to health care under Article 7(1) of Act CLIV of 1997 on Health Care (hereinafter the Act) in violation of Article 8(g) of the Act and Article 25 of the Convention on the Rights of Persons with Disabilities.

[255] By failing to comply with its duty to monitor as set out in point 1), the defendant II maintained, and there was an imminent risk of an imminent risk of a violation of the right to equal treatment of an unspecified number of persons with disabilities accommodated in the Tophaus, in violation of Article 8(g) of the Ebktv, by failing to ensure access to justice for the persons concerned and thereby discriminating against them.

[256] It requested the General Court to declare, pursuant to Section 2:51(1)(a) of Act V of 2013 (Civil Code), that the legal relationship between the company of 2131 Göd, Munkácsy Mihály u. 2. in respect of the unspecified number of disabled persons accommodated in the House of Care for Disabled People of the Hungarian Maltese Charity Service (hereinafter 'House of Care'), the defendant No VI, as the maintainer of the House of Care, has failed to ensure the proper functioning of the institution in accordance with Article 92/C(1)(b) of the Social Act, by failing to take the necessary measures to ensure the right of the disabled persons to be accommodated in the House of Care for Disabled Persons of the Hungarian Maltese Charity Service (hereinafter 'House of Care') in accordance with Article 92/C(1)(b) of the Social Act.

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maintains its lawful operation as provided for in point 1.1, and thereby itself achieves, or is in imminent danger of achieving, the objectives set out in point 1.1-1.6 of Application No. 1, thereby violating the right to equal treatment of an unspecified number of disabled persons in breach of Article 10(1) and Article 8(g) of the Equal Treatment Act and Articles 7, 14, 15, 24, 26 and 30 of the Convention on the Rights of Persons with Disabilities:

[257] The defendant VI. maintains by its failure as set out in point 2), and in accordance with § 20 of the Ebktv.

(1) According to para. c), there was an imminent risk that this would infringe Section 10(1) of the Ebktv. or, alternatively, Section 8(g) of the Ebktv. and the Convention on the Rights of Persons with Disabilities

maintains a degrading and humiliating environment contrary to Article 15 or directly discriminates against an unspecified number of disabled persons accommodated in the Care Home by

[258] - severely restricts the personal freedom of persons with disabilities in a manner that seriously undermines human dignity, in violation of Article 14 of the Convention on the Rights of Persons with Disabilities.

[259] - organises the cleaning of the persons concerned in a way that is offensive to human dignity and in particular to the dignity of the persons concerned;

[260] - does not provide a healthy, decent living environment for people with disabilities.

[261] The defendant VI. maintains by its failure as set out in point 2), and in accordance with § 20 of the Ebktv.

(1) according to paragraph 8(c), there is an imminent risk that it will not ensure access to education, habilitation and rehabilitation of an unspecified number of disabled adults, as well as their participation in cultural life, recreational, leisure and sporting activities, in violation of Article 8(g) of the Social Act and Articles 24, 26 and 30 of the Convention on the Rights of Persons with Disabilities, and Articles 67 and 70 of the Social Act.

(3), the provision of full care, continuing, skill-developing employment and sports and leisure activities.

[262] The defendant VI. maintains by its failure as set out in point 2), and in accordance with § 20 of the Ebktv.

(1)(c), there is an imminent risk that it will violate the right to equal treatment of an unspecified number of disabled children by directly discriminating against them in violation of Article 8(g) of the Equal Treatment Act by failing to provide them with early development and care in accordance with Article 3 of the Convention on the Rights of the Child and Articles 7 and 24 of the Convention on the Rights of Persons with Disabilities, as provided for in Article 70(2) of the Social Act.

[263] The defendant VI. maintains by its failure as set out in point 2), and in accordance with § 20 of the Ebktv.

(1) According to Article 46(3)(c) of the Act, there is an imminent risk that it will violate the right to equal treatment of an unspecified number of disabled children by not ensuring their right to education according to their ability pursuant to Article 46(3)(a) of the Act, in violation of Article 8(g) of the Act and Article 24 of the Convention on the Rights of Persons with Disabilities.

[264] The defendant VI. maintains by its failure as set out in point 2), and in accordance with § 20 of the Ebktv.

(1) (c), there is an imminent risk of infringing the right to equal treatment of an unspecified number of disabled persons by failing to ensure the right to health care under Section 7(1) of the Social Security Act in violation of Section 8(g) of the Social Security Act and Article 25 of the Convention on the Rights of Persons with Disabilities.

[265] The VI defendant directly discriminates on the basis of Article 8(g) of the Act on the Protection of the Rights of the Child when it does not grant access to justice to the residents of the House of Care.

[266] He requested the General Court to apply the provisions of the RPC in relation to Topház.

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84(1)(a) of the Civil Code, and in relation to the House of Providence, in accordance with §
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order that the defendant III. as the body authorising the operation of the Topház and the Gondviselés Háza is to be subject to the provisions of the Act No. 369/2013 (X.24.(hereinafter referred to as the "Snyr"), in accordance with Article 36(1)(a) and (d) of the Government Decree of 27.5.2013 and Article 40(1) of the Snyr, and by failing to apply the necessary legal sanctions, the harassment and direct discrimination in the Topház, as described in the applications No 1 and 2, against an unspecified number of disabled persons accommodated in the Topház and the Gondviselés Háza, in breach of Article 10 of the Ebktv. (1) paragraph 8(g) of the Ebktv. and Section 8(g) of the Ebktv. and Section 7 of the Convention on the Rights of Persons with Disabilities.

14. 15. 24. 26. and 30. of the Act on the Protection of the Rights of the Child, and there was an imminent threat of this in accordance with Article 20 (1) (c) of the Act on the Protection of the Rights of the Child, and it is still maintained or there is an imminent threat of this in the House of Providence.

[267] He asked the General Court to apply the provisions of the RPC in relation to Topház. 84(1)(a) of the Civil Code, and in respect of the House of Providence, in accordance with § 2:51(1)(a) of the Civil Code, that the defendant IV. defendant IV, as the managing bodies of the social policy and social sector and as the managing bodies of the defendant II (Annex 1, point C), sub-point 12 of Government Decree No 152/2014 (6.VI.) and Government Decree No 182/2022 (24.V.) of 20.12.2012). Decree No. 182/2022, Annex 1, point E), sub-point 13) have maintained the harassment and direct discrimination described in the above points of action until 30 June 2018 in relation to the Topház, and have maintained the harassment and direct discrimination described in the above points of action in relation to the Gondviselés Háza from 1 July 2018, and the imminent threat thereof has existed pursuant to Article 20 (1) c) of the Ebktv.

[268] The defendant IV. until 25 May 2022, and thereafter its successor, the defendant VII. pursuant to this action, in accordance with Section 10 (1) of the Ebktv. and Section 8. § 10(1)(1)(g) of the Act of Accession of the Republic of Hungary on the implementation of the above-mentioned infringement by failing to carry out the checks required of them by law (§ 52(2)(c) and § 59(2)(ab) of Government Regulation No 152/2014 (6 June 2014); § 52(2)(c) and § 59(2)(ab) of Government Decree No 182/2022 (24 May 2012) of 24 May 2012 on the implementation of the above-mentioned infringement by failing to carry out the checks required of them by law (§ 52(2)(c) and § 59(2)(ab) of Government Decree No 182/2022 (6 June 2014))). rendelet 89. § (2) c), 92. § (2) ab) pontja; az Államháztartásról szóló 2011. évi CXCV. törvény 9. §; illetve a Gondviselés Háza vonatkozásában a VI. r alperessel kötött Támogatási szerződésben, illetve a Pest Megyei Topház Egyesített Szociális Intézmény kiváltásával és a szociális, gyermekjóléti és gyermekvédelmi intézményrendszer ellenőrzésének megerősítésével kapcsolatos feladatokról szóló 2051/2017. (XII.27.) in connection with the care of disabled persons accommodated in the Topház and then in the Gondviselés ház, and failed to apply the legal consequences necessary to terminate the violations of the law on the basis of the inspection.

[269] He asked the General Court to apply the provisions of the rPtk. 84(1)(a) of the Rules of Procedure of the Court of First Instance of the European Communities.

r. the defendant, as the ministry responsible for the management, regulation and control of the development earmarked funds, maintained the harassment and direct discrimination described in the above points of claim in breach of Article 10(1) of the Ebktv. and Article 8(g) of the Ebktv., and the imminent threat thereof in breach of Article 20(1) of the Ebktv. (c) of the EC Treaty by granting development aid to the defendant in the context of the KEOP-5.7.0/15-2015-0246 project, and by failing to comply with the provisions of Decree No 4/2011 of 28 January 2011 on the rules for the use of aid from the European Regional Development Fund and the Cohesion Fund for the 2007-2013 programming period (1 ..) of the Government Regulation (EU) No .../2011/2011 on the implementation of the Structural Funds and the Cohesion Fund.

- [270] Ban the rPtk. order the defendant VIII under Article 84(1)(b) and the defendants III-VI-VII under Article 2:51(1)(b) of the Civil Code from continuing the discriminatory practices set out in the applications Nos 1 to 5, and at the same time prohibit the defendant VI from admitting new persons to the care home it maintains from the day after the judgment becomes final.
- [271] He brought the same action against defendant IX as he did against the predecessor defendant VIII.
- [272] He requested the court to order the defendant VI to cease the infringement pursuant to Section 2:51 (1) (d) of the Civil Code by ceasing the use of measures unlawfully restricting the freedom of all persons concerned in the House of Care maintained by him on the day after the judgment became final, including the use of physical restraints, caged or raised beds or psychotropic and other drugs as chemical restraints without the free and informed consent of the person. In addition, ensure the protection of the personal liberty and physical integrity of all persons concerned by training the caregivers employed in the Care Home it maintains, with the assistance of an external expert, in the use of de-escalation techniques that trigger restraint. Document the implementation of the above measures and send it to the applicant or allow him to verify its implementation by visiting the care home.
- [273] Within 2 months of the judgment becoming final, assess the physical and mental condition and needs of all disabled persons placed in the Care Home with the involvement of an external doctor (paediatrician, pathologist, dermatologist, gynaecologist, dentist, neurologist, psychiatrist), psychologist and special education teacher, and, on the basis of the assessment, immediately start the necessary emergency medical and developmental care, including the necessary medical, psychological and special education therapy. The assessment shall cover the person's medical, psychological, in particular the consequences of any trauma caused by institutionalisation, and disability-related conditions, as well as the person's educational, therapeutic and therapeutic needs, and employment-related, social and communication skills.
- [274] On the basis of the assessment of the beneficiaries under point 7.2, develop an individual (re)habilitation and integration plan for each resident within 2 months of the judgment becoming final, which will define the individual areas and objectives of (re)habilitation of the person concerned and the pace and exact course of his/her integration into community care. The integration plan should include the ways in which the person will access health, mental health, (re)habilitation, education, vocational training, employment, leisure and social services in the community based on individual needs, including the location and regularity of access. Send all individual (re)habilitation and integration plans to the applicant within 2 months of the judgment becoming final, without any means of identification.
- [275] Within 1 month of the judgment becoming final, take the necessary steps to ensure decent and hygienic housing and sanitation for the residents.

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- [276] As of the day after the judgment becomes final, cooperate with NGOs working for the protection of the rights of persons with disabilities, including the plaintiff foundation, in order to promote access to justice for persons with disabilities, inter alia by allowing independent, civilian experts to visit the institution in a meaningful way, including by allowing confidential (private) discussions with the beneficiaries.
- [277] Within 2 months of the judgment becoming final, develop a one-year action plan to improve the effectiveness of complaints mechanisms to ensure adequate redress for beneficiaries, and to ensure access to legal aid.
- [278] Within 2 months of the judgment becoming final, develop a one-year action plan to ensure that communication with all beneficiaries is accessible, in the context of effective information on access to complaints mechanisms, legal aid and information.
- [279] Document the implementation of the action plans and send this documentation to the applicant on a quarterly basis.
- [280] Within 12 months of the judgment becoming final, ensure the closure of the institution and the community placement (deinstitutionalisation) of all disabled persons living in the House of Care, including the resources to cover this and ensure that they have access to the necessary community services (basic and specialised social services available in the community) according to their needs. Provide a report on this, showing where the persons concerned have been moved to and what support and services they have received to enable them to be socially included, and send the report to the applicant.
- [281] Order Defendants III and VII to verify the following pursuant to Section 2:51 (1) (d) of the Civil Code
7. enforce the measures specified in the application and, in the event of a breach of law, order the defendant in Case VI to remedy the deficiency or infringement, setting a time-limit. Report in detail to the applicant on the monitoring of the implementation of Application No 7 within 7 months of the judgment becoming final.
- [282] He explained that pursuant to Section 88 (1) of the Social Act, the State, through the body designated by Government decree to perform its maintenance functions, is obliged to ensure, inter alia, the organisation and maintenance of specialised care in the territory of the county. A 316/2012. (XI. 13.) Korm. rendelet 4. § (1) bekezdésében a Kormány a Szociális és Gyermekvédelmi Főigazgatóságot jelöli ki az egyes szakosított szociális és gyermekvédelmi szakellátási intézmények állami átvételéről és egyes törvények módosításáról szóló 2012. évi CXCVII. törvény 2. § (3) bekezdése, a 9. § In addition, Government Decree No 316/2012 (13.XI.) provides that in the case of institutions not listed in Annex 1 of the Decree, the maintenance functions shall be performed by the branch office of the Directorate General. In the case of the defendant I.r., this is the Pest County Branch of the Directorate-General for Social Affairs and Child Protection.
- [283] Paragraph (3) of Article 92/A of the Social Act stipulates that the maintaining authority is obliged to ensure the conditions for the continuous operation of the social institution, which the state shall assist by announcing social professional programmes. The state maintainer of a social institution providing personal care shall, inter alia, monitor the legality of the operation of the institution; approve the organisational and operational rules, the professional programme and the house rules of the institution; monitor and evaluate the effectiveness of the professional work once a year; ensure the training and further training of professionals and exercise the rights of the employer in respect of the head of the institution. The public authorities shall be responsible for approving the organisational and operational rules, the rules of procedure and the professional programme

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shall refuse to grant the application if it does not comply with the conditions provided for in this Act and in the special legislation. And if, in the course of its inspection of the operation of the institution, it finds an infringement of the law, it must take measures to put an end to it.

- [284] Pursuant to Article 13 of the SzCsM Decree, the state maintainer, in the light of its duties as a maintainer as defined in the Social Act, "shall at least once a year inspect and, on the basis of this inspection, comprehensively evaluate the operation of the institution providing personal care. The evaluation shall include in particular
- [285] a) the practice of admission to the institution, the examination of the content of the agreements concluded and the professional analysis of them,
- [286] b) the implementation of the professional programme for the performance of the institution's tasks,
- [287] c) the general conditions of operation of the institution, the material, personnel, operational and professional conditions,
- [288] d) the efficiency and effectiveness of the care plans, in line with the nursing care work in the institution,
- [289] (e) the role of the institution in the local social care system and the known trends in the needs of the recipients."
- [290] From the foregoing, it is clear that Defendant II has a regular duty to monitor Defendant I, its acceptance of the institution's basic documents and its responsibility to remedy the breaches it has discovered clearly establish its liability for the breaches of personality rights alleged in the above claims.
- [291] It referred to the fact that the 2016 Sustainability Impact Assessment provides a detailed and devastating picture of the massive human rights violations at the I.r. defendant. It is questionable how previous annual inspections did not reveal violations, when, for example, the circumstances regarding the physical condition and infrastructure of the institution certainly did not develop from one year to the next.
- [292] It is clear from the Ombudsman's report that the audit carried out by defendant II in 2015 found everything to be in order, which implies that the audit was either not carried out or, if it was, the true results were concealed.
- [293] The failure of the defendant II to check and take action to remedy the infringements it discovered following its 2016 inspection is also evidence of the defendant's failure to act. This is evidenced, first, by the shocking conditions shown in the photographs taken by the applicant's staff between February and April 2017 and, second, by the fact that defendant IV imposed measures on defendants I and II with almost the same content as the recommendations made by the 2016 inspection, one year later, on 30 May 2017.
- [294] The liability of defendant II therefore consists in the fact that it tolerated and thus perpetuated the discrimination against the disabled persons served by defendant I, as set out in the complaints, and failed to exercise its legal obligations to monitor and remedy the infringements.
- [295] The defendant III.r., who authorised the operation of the Social Act, has submitted that the Government designates the Metropolitan and County Government Office as the body authorising the operation of the Social Act. Section 90/A of the Social Act authorises the social authority - which in the case of the defendant I.r. is the competent government office of the Pest County Branch of the SZGYF pursuant to Section 3 (2) of the Social Act - to apply the Social Act, and, if the SZGYF fails to fulfil its duties arising from its duty to provide care, in particular its maintenance duties, to call upon it to do so by setting a suitable time limit.
- [296] According to the Snyr., the Government Office is obliged to carry out an annual inspection of the home care provider's operation in accordance with the legislation and the register of providers. In addition to the normal inspection, the

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the licensing body also carries out an on-site inspection if it becomes aware that the personal, material conditions or operation of the licensee endanger the life, physical integrity or health of the persons provided for or the development of the children provided for, or infringe the rights of others, or that the legislation or the provider's register relating to the operation of the licensee has been seriously infringed.

- [297] In his report, the Commissioner for Fundamental Rights, who has been quoted several times, specifically referred to the general phenomenon that the inspections of the maintaining body and the government office - as the body authorising the operation - differ in many respects. The Commissioner for Fundamental Rights expressed his concern that "the official inspections of government agencies are in many cases mainly focused on the examination of documentation and the compliance of the documentation system with the legal requirements" (Ombudsman's report, p. 31), although the above-mentioned Article 36. According to §§ (2) to (4) of the SNYC, the body authorising the operation of the institution must also carry out an on-site inspection during the course of a normal inspection if it becomes aware that the personnel, material conditions or operation of the institution endanger the life, physical integrity, health or development of the children served. As the Commissioner's report points out, in the case of the defendant I.r., the inspections carried out in the same year by the government agency and the maintenance agency contradict each other in a number of cases, and the inspection by the government agency is less detailed and of a lower quality than the maintenance agency's inspection.
- [298] Defendant III is therefore liable for having tolerated and thus perpetuated the discrimination against the disabled persons served by Defendant I in the claims, and for having failed to exercise its statutory obligations to monitor and remedy the violations.
- [299] The defendant IV.r., responsible for sectoral management, submitted that Annex 1 of Government Decree No. 52/2014 (VI. 6.) on the tasks and powers of the members of the Government
Pursuant to paragraph (C)(12), Defendant II shall be controlled and supervised by Defendant IV. The Ministry, as the managing body of the social sector and as the central state administration body supervising and directing the defendant II.r., is, pursuant to Article 2(1) of Act XLIII of 2010 on the Status of Members of the Government and State Secretaries, *inter alia*
the legality, regularity, efficiency and financial control of the defendant II.r. (point c) and the power to issue individual instructions to the defendant II.r. under its control to perform a task or to remedy a default (point g).
- [300] Defendant IV's plan of action dated 31 May 2017, which sets out tasks for Defendants I and II, could only have been drawn up after the applicant had made public the appalling conditions at Defendant I. However, in its detail and thoroughness, the 2016 maintenance audit certainly provides a much more accurate picture of the infringing practices of the 1st Defendant, as the 2nd Defendant's staff had free access to the entire institution and all documentation. Based on the 2016 maintenance audit detailed in the Ombudsman's report, Respondent I.r. should have been required to take immediate action, at least to the extent that it was instructed to do so in the action plan of 31 May 2017.
- [301] However, the defendant IV. could not have become aware of the infringements at the defendant I. only on the basis of the 2016 inspection of the maintenance authorities, but as a managing authority it must ensure the lawful operation of the institutions under its control on a regular basis, or at least during annual inspections.
- [302] The measures contained in the action plan issued as a result of the extraordinary inspection ordered by defendant IV can be considered as an admission of the infringements that are the subject of the plaintiff's action, since defendant IV reached the same conclusion as the plaintiff in the scope of the facts of the action as to the infringements committed against the disabled persons living with defendant I.

- [303] Defendant IV is therefore liable for tolerating and thus perpetuating the discrimination against disabled persons served by Defendant I in Claim Nos. 1-6, and for failing to exercise its statutory obligations to monitor and remedy the violations.
- [304] In 2015, the defendant II received HUF 149 981 365,- in European Union funding under the KEOP-2015-5.7.0 tender scheme of the Environment and Energy Operational Programme to carry out the energy modernisation and improvement of the Tophaus building under its maintenance. Following the successful tender, the façade and facade of the building were renewed and the external windows were replaced.
- [305] According to the General Guidelines for Applicants of the Environment and Energy Operational Programme, the maintenance period of the project is 5 years from the day after the project is completed, which in the case of the Tophaus is December 2020. This means that, during the maintenance period, Tophaus undertakes, under the obligation to repay the grant, not to make any significant changes to the supported installation or activity that would affect its nature or its implementation conditions. This requirement is based on Article 57(1) of Regulation (EC) No 1083/2006 and Article 80 of Government Decree No 4/2011 (28.1.2011), which essentially requires all EU support to be conditional on the beneficiary undertaking not to cease its activities for a specified period after the support.
- [306] As the subsidy contract concluded between Defendants IV and VI also stipulates that the House of Providence is to be vacated by 31 December 2020, it is clear that the use of EU funds has indeed prevented the situation of the residents of the institution from improving before then.
- [307] In the case of the Environment and Energy Operational Programme, following the dissolution of the National Development Agency (NDA), the successor of the managing authority of the NDA was the Ministry of National Development, as set out in Annex 1 to Government Decree No. 475/2013 (17.XII.), and following the succession, the defendant V.r. The functions of the defendant V.r. as managing authority are defined in Council Regulation (EC) No 1083/2006 and the relevant national legislation, namely Government Regulation No 4/2011 (28.I.) on the rules for the use of assistance from the European Regional Development Fund, the European Social Fund and the Cohesion Fund for the 2007-2013 programming period.
- [308] According to Article 5/A(1)(k) of Government Decree 4/2011, the defendant V.r., as the managing authority, "decides on the granting or rejection of project proposals, concludes the grant contract with the beneficiary, issues the grant deed, ensures the payment and proper use of the grants."
- [309] Article 60 of Regulation (EC) No 1083/2006 establishes that the managing authority has primary responsibility for the sound and efficient management and implementation of the Structural and Investment Funds, including responsibility for ensuring that operations selected for funding comply with the conditions applicable to the operational programme and that they comply with the relevant Community and national rules throughout the period of their implementation. The managing authority therefore performs a number of functions linked to programme management and monitoring and financial management and control. Among other things, the defendant V.r. is responsible for preparing calls for proposals, evaluating proposals, monitoring the funded project and carrying out first-level checks.
- [310] Regardless of the fact that the list of potential applicants was established by the Government in Government Decree 1290/2015 (V. 5.) According to the Call for Proposals of the KEOP-2015-5.7.0, the Managing Authority was responsible for the preparation and the decision on the grant of the funding, during which the eligibility of the project idea for EU funding, its adequate preparation and its consistency with the other priority project ideas were examined by the defendant.

- [311] The Environment and Energy Operational Programme (EEOP) for 2007-2013 sets out a number of horizontal principles that must be applied when using the funds. The aim of mainstreaming horizontal criteria is to ensure that projects are sustainable and equitable, that they develop the area to be supported without causing economic or social damage to the environment and that they mitigate and, as far as possible, improve existing undesirable conditions in the area concerned. In accordance with Articles 30(30) and 16 of Regulation (EC) No 1083/2006, the OP requires that the principle of equal opportunities and non-discrimination be applied in the implementation of the Operational Programme, which the managing authority must ensure.
- [312] According to page 45 of the KEOP Operational Programme:
- [313] "With regard to equal opportunities, the KEOP shall ensure the promotion of equality between women and men and the principle of gender mainstreaming at the various stages of the design, implementation, monitoring and evaluation of the operational programme, including special attention to the employment of target groups for equal opportunities. In addition, the OP shall ensure compliance with the prevention of any discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation, in particular as regards access to funds." Later on (p. 98), it is also made clear that the NFIO, i.e. the legal predecessor of the defendant V.r., is "responsible for the coordination of the planning, programming and implementation of operational programmes, for the enforcement of Community policies and horizontal aspects such as sustainability, equal opportunities and non-discrimination, partnership, public procurement and, in cooperation with the Subsidies Control Office of the Ministry of Finance (PM TVI), of the State aid rules. "
- [314] It can be seen from all the above that the task of the defendant V.r. was also explicitly to enforce equal opportunities and non-discrimination in the operational programmes.
- [315] The liability of defendant V. consists in the fact that defendant II. granted significant amounts of EU funding to Topház for the energy modernisation of the building of the Special Home Topház in Göd, and that this funding was not intended to remedy the infringements which are the subject of the present action, even though the operation of Topház was already contrary to national and EU standards and principles when the funding was granted. That should have been ascertained by the defendant V.r. at the time the aid was granted, as is laid down in the detailed rules for the assessment of compliance with the horizontal criteria set out above.
- [316] In light of the above, it can be concluded that the defendant V.r., as managing authority, did not comply with the provisions of the Operational Programme and supported the implementation of a project which, at least for the duration of the project, maintained and supported the institutional system in which the discrimination described in the complaints could have occurred against the disabled persons accommodated in the Tophaus.
- [317] Consequently, the defendant V.r. itself contributed to the maintenance of the unlawful situation as defined in the application by failing to carry out the checks required of it, and is therefore, in our view, liable for having maintained the discrimination against disabled persons in the Tophaus as defined in applications 1 to 6 by awarding the EU subsidy with maintenance obligations and by failing to carry out the checks on the equality of opportunity aspects relating thereto.
- [318] Defendant VIII as the successor in title to Defendant V:
- [319] Pursuant to Article 178 (1) (4) of the Government Statute, the Minister for Spatial Development shall be responsible for the use of European Union funds, and shall be assisted in his/her work by the

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The applicant sought only an injunction against the defendant No VIII from engaging in future infringing conduct, since its predecessor had not ceased to exist.

[320] The responsibility of the defendant VII for the control of the defendant VI:

[321] In 2017, the Government granted additional resources to the legal predecessor of defendant VII, defendant IV (Government Decision 2051/2017 (XII. 27.) on the tasks related to the replacement of the Topház Unified Social Institution of Pest County and the strengthening of the control of the social, child welfare and child protection institutional system) in order to enable the Ministry to exercise more direct control over the tasks related to the replacement of Topház. This control is to be exercised by the defendant VII from 25 May 2022 in view of the succession.

[322] According to the applicant, the measures restricting personal freedom in the Tophaus and the Gödi House of Care are contrary to the prohibition of torture and constitute an extremely serious violation of the human dignity and physical integrity of the persons concerned. The restraint, caging and other measures used against the persons concerned on account of their disability, which are oppressive to the persons concerned in the ways set out below, are a serious violation of their human dignity and have created an environment of shame for them. On the basis of all these elements, they amount to harassment within the meaning of Article 10(1) of the Act.

[323] In its preparatory document of 2 March 2022, the applicant commented in detail on the combined expert opinion. With regard to the restrictive measures, he pointed out that the Hungarian legal environment does not comply with the provisions of the Convention on the Rights of Persons with Disabilities (CRPD) and the guidelines of the CRPD Committee. In its Guidelines on the Right to liberty and security of persons with disabilities, the CRPD Committee called on States Parties to "protect the safety and personal integrity of persons with disabilities deprived of their liberty, including by eliminating coercive treatment, segregation and the use of various restrictive methods, including physical, chemical and mechanical restraints, in health care institutions. The Committee has found that these practices are not in line with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment of persons with disabilities under Article 15 of the Convention." [CRPD Committee (2016): Guidelines on the right to liberty and security of persons with disabilities (Article 14). It is clear from the Commission's jurisprudence that this position applies not only to health care institutions, but also to social and child protection institutions. In its report issued following its examination of Hungary under Article 6 of the Optional Protocol to the CRPD, the CRPD Committee concluded that "[persons with disabilities] living in residential institutions are exposed to mechanical, physical and chemical restraints and other forms of ill-treatment." [CRPD Committee (2020). CRPD/C/HUN/IR/1. paragraph 77.]

[324] The Hungarian legal environment does not comply with the CRPD and the CRPD Committee's guidelines on the use of restrictive measures.

[325] The CRPD Committee has on a number of occasions expressed concern about the use of physical and chemical restraints and called on the States concerned to cease such measures with immediate effect. Manfred Nowak, the UN Special Rapporteur on torture, also stressed that "prolonged use of restraints can lead to muscular atrophy, life-threatening deformities or even organ failure, and can exacerbate psychological trauma." It also stresses that the prolonged use of restraints, which

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may lead to torture or ill-treatment - there can be no therapeutic justification for any of these.

- [326] In other words, it follows that any such restriction is unlawful, even if some of the ways in which it can be imposed are otherwise provided for in domestic sectoral legislation. This is also the conclusion of the Joint Expert Opinion: "The domestic legal obligations in neither the social nor the educational sectors contain requirements that would enable a specialised social institution providing long-term residential care (in this case, a care home for persons with disabilities) to provide all the conditions and human rights standards required by the CRPD." (20.o.)
- [327] Restriction of personal freedom in the Tophaus: The applicant experienced that the residents of the Tophaus were subjected to permanent, lifelong restrictions on their personal freedom, being tied up in an inhuman and degrading way, being locked in a cage-like bed with bars, being restricted in their movements by a homemade straitjacket or having socks put on their hands. The Ombudsman has also proposed an immediate end to the restraint of a resident tied at the ankles, in
And in Defendant IV's plan of action, Defendants expressly instructed Defendants to cease and desist from restrictive measures with respect to non-medical aids.
- [328] What the claimant experienced in the spring of 2017 was known to the defendants. According to the 2016 maintenance inspection
- [329] - beds with bars and living quarters with wooden shelters were found in the central building;
- [330] - three-sided beds with bars, the open part of which was turned upwards, so that the patients could not leave of their own free will;
- [331] - the body of a resident was secured (tied down) with a sheet;
- [332] - several residents were confined to special chairs that were not suitable for their physical condition (Ombudsman's report, p. 12).
- [333] The 2016 report of the Ombudsman found that "The beds with bars, as well as the bars on the doors of the rooms and the restraints violate the right to freedom of movement and the right to human dignity of the persons in care" (Ombudsman's report, p. 18). Among the measures and recommendations made in the report of the Ombudsman's inquiry were the removal of "unjustified restrictions on some of the persons concerned, in particular the use of bars on beds and wooden partitions separating rooms" (Ombudsman's report, p. 18).
- [334] As in 2016, the Fundamental Rights Commissioner found that
"The rights of care recipients have been impermissibly violated" (Ombudsman's report, p. 30). During the on-site inspection on 19 January 2017, the Ombudsman's staff met a young man tied by his legs on the floor level, who was tied to the foot of the bed and therefore lying on the floor (Ombudsman's report, p. 4) (The complainant's staff also met the man during their visit in February (photo 2, referred to in several places as BJ))
- [335] In the one year between the report of the Maintenance Report and the Ombudsman's inquiry, there has therefore been no positive change in the restrictive measures, the Tophaus is obliged to monitor II,
Defendants III and IV failed to exercise their powers, and their failure to exercise their powers contributed to the maintenance of the infringing situation.
- [336] The photos taken by the applicant show that in the Tophaus, high beds with bars similar to a cage were used on a massive scale for both adults and minors (see e.g. photos 15, 16, 17, 18, 19, 49), although the use of beds with nets and similar bars with a closed structure resembling a cage is expressly prohibited under Article 4(4) of the Decree on the use of cages.
- [337] According to the plaintiff, the restrictive measures applied by the Tophaus, but tolerated by the defendants II-IV, who are obliged to control it, are contrary to the prohibition of torture, the most serious discrimination against persons with disabilities. They are, first, unjustified and, second, they are unlawful, inhuman and degrading and, finally, they are

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restrict residents by completely depriving them of personal freedom. Within the concept of harassment as used by the Ebktv., the practice used by the defendants is the most consistent with the statutory definition of harassment, since the restriction of the personal freedom of residents as claimed, apart from being harmful to health, is clearly an affront to human dignity and creates a degrading and humiliating environment for the victims of the restriction.

[338] Restrictions on the personal freedom of residents in the Gød House of Welfare:

[339] Since the applicant was not able to personally verify the restrictive measures currently applied in GGH, we consider the combined expert opinion to be authoritative and refer back to the inspections of the defendant III.r., which found deficiencies in general for the period 2018 and 2019, without specifically addressing the restrictive measures.

[340] According to the joint expert opinion, chemical and physical restraints continue to be used at GGH. This is contrary to the prohibition of torture under the CRPD Convention. The use of raised beds with bars (p. 12) has been retained in the institution, according to the new director, for the safety of the residents. With regard to the use of raised beds, the expert's opinion merely states the fact of their use and quotes the manager's explanation, but does not itself assess, i.e. does not give any guidance to the court, whether their use is indeed justified, appropriate or lawful. These are the cot beds, the use of which the Tophaus had previously been called upon to discontinue by Defendant III, Defendant IV and the Commissioner for Fundamental Rights.

[341] Overall, it can be concluded that chemical, physical and mechanical restraint measures continue to be used in the GGH in contravention of the CRPD. And although Hungarian legislation allows for this under strict conditions, contrary to the CRPD, GGH does not even comply with these domestic rules.

[342] The current use of trellised beds and raised beds in the House of Care certainly does not comply with the strict requirements of Article 10(4) of the Act, which states that a person's personal liberty may be restricted only in cases of urgent need or in order to protect the life, physical integrity or health of the person or others. Restrictive measures of a torturous, cruel, inhuman, degrading or punitive nature shall be prohibited. The restrictive measure may last only as long as the reason for its imposition persists. The current use of trellised beds and raised beds is permanent, not limited to cases of urgent need, and is therefore illegal.

[343] It is also unlawful, for the same reason, to regularly and permanently use elbow braces and a mobility-restricting blanket.

[344] Violation of the human dignity of residents during cleaning

[345] Top House

[346] The disabled people living in the Tophaus also suffered serious violations of their rights in terms of sanitation: neither the hygiene of the bathrooms nor the toilets was adequate, indecent, and in some cases even contaminated, while on the other hand, the physical hygiene of the residents was ensured through a procedure that resulted in their humiliation.

[347] Regarding the physical conditions, the 2016 inspection of the maintenance staff already found that the condition of the bathrooms in the central building was neglected, they were not properly cleaned, and the dirty bathtubs and bathing trolleys did not allow for proper personal hygiene (Ombudsman's report, p. 15). The Ombudsman's inspection also found that the toilets were all one-stall, with no partitions, no curtains, and no covers. Bathing rooms are also in poor condition, with crumbling plaster and tiles (Ombudsman's report, p. 4).

- [348] The 2016 maintenance inspection found that intimacy during bathing and preparation is not ensured. The lack of shower curtains and toilet boards results in a violation of the human dignity of the residents (Ombudsman's report, p. 15, 18). According to the repeatedly cited report of the Commissioner for Fundamental Rights, an interview with the head of the institution revealed that 10-15 persons were bathed in groups at a time, with everyone being stripped of their sheets and those who could not stand having to lie on the floor of the bathroom, and that in such cases the residents were showered from a distance. According to the manager, there were also occasions when the hot water ran out, so that some of the residents were showered with cold water (Ombudsman's report, p. 5).
- [349] Residents did not brush their teeth with their own toothbrushes, but with 2 shared toothbrushes, although each resident has his/her own toothbrush with his/her name on it, which is kept in a locked cupboard for inspection, i.e. not used (Ombudsman's report, p. 5).
- [350] The action plan issued following the extraordinary investigation ordered by Respondent IV. contains specific tasks related to the above violations in several places, which demonstrates that the above circumstances continued to exist at the time of the investigation. Defendant IV ordered the defendants to carry out the following tasks:
- [351] - Elimination of accident-prone infrastructure, replacement of door handles, toilet seats, replacement of shower curtains (No 8. task)
- [352] - regular dental checks (task 14)
- [353] -regular brushing of the teeth of cared-for persons with their own appliances (Exercise 15)
- [354] - During its on-site visits, the applicant found t h e following concerning the state of the bathrooms and toilets:
- [355] - showers and toilets do not meet basic hygiene standards (photos 10, 23, 26, 31)
- [356] - toilets without seats and doors are a risk of infection (photos 20, 21, 24, 27, 29, 30)
- [357] - the lack of doors and curtains in the toilets and bathrooms is a serious violation of the human dignity of the residents, as there is no basic intimacy.
- [358] House of Providence
- [359] As regards the cleaning of the Gödi House of Welfare, the applicant has only the material of the inspections carried out by the defendants. The extraordinary unannounced inspection of 27 May 2019 of the defendant III. r. in connection with the infrastructure for cleaning found the following:
- [360] in nursing unit A, one toilet is not working, one is displaced and one is missing; there are diapers on top of the cupboards
- [361] in Care Unit C, the wall surfaces of the bathrooms show extensive soaking and wall cracking;
- [362] the toilets are only partially intimate.
- [363] While in the case of Topház there is ample evidence of violations related to the cleaning of the residents, in the case of GGH only the findings of the extraordinary inspection of the defendant III. r. in May 2019 are known. However, the above-quoted findings contained therein demonstrate that the human dignity of the residents in relation to cleaning remains limited.
- [364] The inhuman living environment of the residents
- [365] Several sections of Decree No. 1/2000 (I. 7.) of the SzCsM on the professional tasks and operating conditions of social institutions providing personal care (hereinafter: SzCSM Decree) detail the material conditions that a residential institution must meet. Article 3 of the Regulation lays down the principle that the head of the institution shall ensure that human and civil rights are upheld within the institution, that a humanised environment is created and maintained which accepts the autonomy of the individual and promotes his or her integration by all means.
- [366] And under the Regulation, housing is based on age, health and marital status

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or situation-appropriate, short- or long-term housing which promotes personal security and dignity, participation in learning, employment and community life, and the maintenance of contact between family members.

[367] The most important substantive conditions are set out in Section 4(b) of the SCSM Regulation, Section 41(4)(a) and (b) of

b) and § 42 (1). In addition to the above, the defendant I.r. must comply not only with the requirement of accessibility, but also with the requirement of reasonable accommodation, which, according to the definition of the Convention on the Rights of Persons with Disabilities, means

"means necessary and appropriate modifications and adaptations that do not impose a disproportionate and undue burden and are necessary, where appropriate, to ensure the equal enjoyment and exercise by all of the fundamental human rights and freedoms of persons with disabilities." According to the applicant, it follows from all these provisions and legal obligations that the defendants are obliged to provide housing conditions for persons with disabilities which, on the one hand, meet the basic safety requirements and ensure a humane (humanised) environment, and, on the other hand, to provide a suitable housing environment for residents with different mental, health and physical conditions, differentiated according to the specific needs of the persons concerned.

[368] Top House

[369] The Tophaus did not meet the basic conditions for all people, such as safety, hygiene, accessibility and, above all, community accommodation.

[370] A 2015 inspection by the Government Office found the institution to be overcrowded, with an average of 5-6 people per room, compared to the required 4 (Ombudsman's report, p. 5). The 2016 maintenance inspection found that the institution did not meet the physical conditions set out in the SSCM Regulation: 'The building is unkempt and there is a lack of cleaning. Corridors are cluttered with furniture, bags and rubbish. Some residents were lying on beds without sponges, or on sponges smaller than the size of the bed, or even incomplete sponges. Some of the sponges were worn, torn and soiled with urine.' (Ombudsman's report No 11) The investigation found shocking accommodation, with some residents sleeping without a mattress on wooden or wooden beds. Some rooms were found to lack blankets and pillows. (Ombudsman's report p.18.) "Bed linen is partially provided, and in some rooms, residents are not provided with adequate mattresses or bedding." (Ombudsman's report p. 15) The inspection also specifically addressed the provision of textiles, the hygiene of the institution, the right to safety and the right to physical and mental health of the residents in relation to the housing conditions. According to the inspection, "disinfection and cleaning in the institution are ineffective, and a hygienic environment free of infection is not ensured." (Ombudsman's report, p. 16) According to the investigation, refrigerators are not cleaned, expired foodstuffs have been found, medicines are not properly stored, cleaning is not carried out using appropriate disinfectants and methods, and dirty nappies are not properly stored.

[371] In the context of the right to safety, the maintainer noted that the upstairs rooms were used for people with reduced mobility or who were unable to leave their beds independently, so that in the event of a fire, the rescue of the residents on the floor was not guaranteed (Ombudsman's report, p. 18).

[372] The Ombudsman's staff also found, on the basis of the on-site inspection, that the building is in a very poor state of repair, is not accessible and the rooms are overcrowded (Ombudsman's report, p. 4).

[373] During his on-site visits, the applicant found the following:

[374] Infected walls covered with human excrement (photos 34, 40).

[375] Dirty bed linen, broken beds, no stimulation, poor, not child-friendly

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equipment (no. 3, 4, 5, 6, 7, 8, 11, 12,18, 32, 33, 38,41, 42, 50, 53, 54, 55, 56, , photos no.)

- [376] Most of the rooms were very cold.
- [377] Traces of faeces and urine were also found on the sheets, beds, bathrooms and uncleaned toilets (photos 30, 31, 34, 40).
- [378] Some residents are wearing hand-stitched clothes made from mismatched bed sheets, which have made it difficult to move around (51, 49, 44, photo)
- [379] The complainant's staff found a teenage boy wrapped in a dirty duvet cover. He was visibly shivering from the cold. He was wearing shoes even in bed, presumably to keep him from getting too cold. The complainant's colleague estimated the room temperature at 10-12 degrees Celsius (Photo 44).
- [380] One bed-bound resident interviewed, who was placed in an upstairs room and expressed serious concerns about not being able to get out of the room in the event of a fire, even in a wheelchair.
- [381] The extraordinary investigation of defendant IV also concluded that the residential rooms were overcrowded, so it ordered the reduction of the number of residents to 4 (task 2); the revision of the cleaning regime of the institution (task 9), and the making of the residential rooms more stimulating and homelike, taking into account the age and needs of the residents (task 29).
- [382] House of Providence
- [383] Information on the living conditions in the House of Care in Göd is provided by the findings of the on-site inspection of the 3rd respondent Váci District Office of 11 June 2019, which was initiated on the basis of a complaint, and the findings of the extraordinary on-site inspection of the 3rd respondent of 27 May 2019.
- [384] The findings of the inspection of 27 May 2019 showed that the walls of the building are contaminated and damaged in several places, the walls and floors of nursing unit B are damaged, and the walls of the bathrooms in nursing unit C have extensive soaking and wall cracking. In nursing unit D, a door and floor are damaged. The Government Office found that the condition of the residents' rooms in the facility is tidy and clean, but there are signs of damage to doors, floors and walls.
- [385] According to the inspection of 11 June 2019, the roll-away beds in room 31 of corridor B are constantly knocking the plaster off the beds, mattress and floor, which is contaminating the beds, mattress and floor. The condition of the plumbing pipes is causing mould on the walls due to continuous soaking.
- [386] In summary: the housing conditions in the former Tophaus were grossly unlawful and the institution was not barrier-free. The living conditions were in several cases contaminated and dangerous (filth, faeces-covered furnishings, walls), and in several cases they were in breach of the prohibition of torture (unheated rooms, beds without mattresses, unclothed residents). The furnishings were bleak, barren, not at all suitable for the stimulation of the residents, and did not take into account the mental and health conditions and special needs of the residents, i.e. they did not meet the requirements of reasonable accommodation. The housing conditions were a serious affront to the human dignity of the disabled residents and in some cases endangered their physical integrity, creating a degrading and humiliating environment for them.
- [387] In the House of Providence, the living environment has changed for the better, but the dehumanised and degraded housing conditions that were criticised in the Top House are still present.
- [388] d) Neglect of disabled persons
- [389] Claims 1.2 and 1.3 and claims 2.2 and 2.3 are based on the lack of care for disabled persons, i.e. their total neglect. Claims 1.2 and 2.2 seek a declaration of neglect of the elderly residents, while claims 1.3 and 2.3 seek a declaration of neglect of the minor residents.
- [390] Homes such as the Tophaus and the Gondviselé House not only have to meet the physical needs of the residents, such as food, housing, clothing, etc., but also have a duty of care, namely the legal obligation to provide the cognitive, psychological and emotional

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at least maintaining their health and improving their existing skills.

- [391] According to Article 44 (2) of the Social Security Decree, care activities are understood as physical, mental and life management assistance, which "involves the restoration and maintenance of the missing or limited physical and mental functions of the service user in the framework of the individual treatment of his social, physical and mental condition."
- [392] Paragraph (3) of Article 70 of the Social Act also provides for individualised, level-maintaining, skill-developing employment, as well as sports and leisure activities.
For minors, the early development and care, or cooperation with the competent local pedagogical specialised service institution providing developmental education, as well as assistance in continuing school studies, must be provided in parallel with care and assistance.
- [393] Section 94/F of the Social Act also stipulates that in order to ensure the rights of persons with disabilities, special emphasis must be placed on the development of abilities and skills and the creation of opportunities for maintaining or improving their condition,
- [394] the principle of self-determination, respect for the disabled person's choices about his or her way of life, and
- [395] the right of persons with disabilities to social inclusion, which includes access to services in the community.
- [396] In addition to respecting and guaranteeing the right to rehabilitation, self-determination and community life, the principle of prevention must be applied to the full range of care provided by social services. Paragraph 2(2) of Article 2 of the Fot. stipulates that conduct and activities in relation to persons with disabilities must be carried out in such a way as to prevent the worsening of the disability or to mitigate its consequences.
- [397] An individual care and development plan must be kept for each person served. The care plan shall specify the care, nursing and development tasks and the methods of their implementation, tailored to the individual's condition. The individual development plan is drawn up on the basis of an assessment of the person's (therapeutic) educational, health and mental state and contains a description of the individualised treatment and the development of self-care skills. Pursuant to Article 8(1) of the Decree, the head of the institution is responsible for the preparation of the care plan.
- [398] Within the framework of mental health care, the institution must provide
- [399] ° personalised treatment,
- [400] ° the implementation of care plans,
- [401] ° psychotherapy sessions as needed,
- [402] ° individual or group discussions to prevent conflict situations from arising,
- [403] ° the conditions for spending leisure time in a cultural way,
- [404] ° to help maintain the family and social relationships of the beneficiaries,
- [405] ° the conditions for practising the life of faith.
- [406] In addition, the institution must do everything possible to maintain and preserve the physical and mental activity of the care recipient, including by promoting and ensuring the participation of the care recipient in physical, recreational or cultural activities that promote activity. The provision of mental health care is the responsibility of all staff of the social welfare institution.
- [407] The lack of mental health care can play a role in situations and conflicts that trigger the imposition of restraints. The provision of as many activities, experiences and physical exercise as possible for the persons concerned plays an important role in preventing escalation of conflicts and situations that can lead to (self-)aggression.

[408] Top House

[409] As detailed below, neither adult nor minor beneficiaries had access to even level of care.

[410] Both the 2016 maintenance audit and the Ombudsman's investigation in early 2017 clearly concluded that the "mental health activities in the Tophaus are not suitable for restoring and maintaining the physical and mental functions that are absent or limited." (Ombudsman's report No 19)

[411] The 2016 inspection report notes that a number of people were found to be unaccompanied and unaccompanied at the time of the inspection. There were some who spent their time by the laundry bags with nappies, but the representatives of the maintenance agency also met residents who "amused themselves by waving a sock". According to the maintenance inspectorate, "care activities are inadequate. The comfort, personal and environmental hygiene of the residents and accident prevention are not ensured. It is essential to introduce a model of assisted care". The inspection also pointed out that the administration of care activities in the institution, such as the management of individual care plans, is inadequate (Ombudsman's report, p. 13).

[412] The findings of the 2016 maintenance audit suggest that the deficiencies in mental health activities are likely to be a consequence of the fact that the care recipients are causing damage. During the inspection, the maintenance representatives observed "occupation", during which about 15 service users were in the canteen, with the exception of 3-4 service users, the others were wandering aimlessly (Ombudsman's report, p. 16).

[413] According to the head of the institution, no rehabilitation activities are carried out at the defendant (Ombudsman's report, p. 17).

[414] The availability of a sufficient number of professionals with the right skills is a prerequisite for providing care for residents in line with professional standards and human rights.

[415] According to the 2016 maintenance audit, 7 nursing posts were not filled at the time of the audit. The applicant's staff observed the presence of 1 and 2 nursing staff during their visits to each of the 40 wards. The Commissioner for Fundamental Rights had already drawn attention to the dangers of understaffing in his report on the Debrecen Therapy House: 'despite the fact that the number of nursing staff is in accordance with the law, there is a situation where a single nurse is present in a nursing unit with more than 50 persons. In addition to being unacceptable for both the recipients and the nursing staff, this work assignment entails a violation of the prohibition of torture and other cruel, inhuman or degrading treatment or punishment and thus creates a risk of an abuse under Article III(1) of the Fundamental Law" (AJB-257/2017, p. 13).

[416] House of Providence

[417] Mental health and care activities in the House of Caring can also be judged in the light of staffing conditions. Following the complaint of the representative of the person entitled to assistance of the defendant VI, the defendant III ordered an extraordinary inspection and appeared unannounced at the House of Care on 27 May 2019. The violations found by the inspection are as follows:

[418] 25

[419] ° an extremely large number of 66 care staff are missing from the institution

[420] ° 2 development teachers missing

[421] ° the home does not have a dedicated development teacher and support

[422] ° only partial intimacy in toilets

[423] According to the joint expert opinion, the staff survey of the institution's staff identified the shortage of staff, the lack of information flow, the inadequacy of training, dialogue, regular case conferences and supervision as the weaknesses to be corrected (p. 11).

[424] Although the number of staff has increased proportionately compared to the Top House, it remains understaffed

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the institution operates, which affects the rights of the beneficiaries. According to the Joint Expert Opinion, the number of staff employed as development teachers is not in line with the legal requirements, and the experts believe that the number of staff should be at least 10 instead of 3.

- [425] It can therefore be concluded that one year after the takeover, on 27 May 2019, the number of vacant care posts at GGH was still alarmingly high, which meant that the institution was unable to provide residents with individualised, quality care, and therefore neglect of residents persisted.
- [426] Neglect of children with disabilities
- [427] In the case of minors, early development and care, or cooperation with the competent pedagogical specialised service institution in the area providing developmental education, and assistance in continuing school studies must be provided in parallel with care and assistance.
- [428] Top House
- [429] In the area of child neglect, the applicant found the following in the Tophaus:
- [430] - The complainant saw numerous children showing signs of stress and neglect, including one who was rocking back and forth on a metal lattice bed (akathisia) and other children who were covering their faces with their arms and hands (Photos 55, 56, 49, 48, 47, 44)
- [431] - The furniture and equipment of the dormitories and the ward were extremely poor, the children had no stimulation, no stimuli.
- [432] - A girl with dark eyes, chewing on a piece of cloth, stood almost motionless in the middle of the room (photo 59).
- [433] - A boy lay motionless on one of the beds, unresponsive to greetings.
- [434] - In a room with six beds, all the children were lying on their backs. The beds were so close together that the children's bodies were touching.
- [435] - The children were in their rooms unsupervised, without any kind of activity, education or development, and although the visit took place during the day, most of them were in bed.
- [436] - Due to lack of supervision, several children have been locked in high-sided cots and prams, with no one to supervise them.
- [437] Overall, the official controls and the applicant's findings show that the disabled people accommodated in the Tophaus did not have access to care that would have been able to maintain and develop their abilities beyond the most basic physical needs. They showed serious signs of neglect which, far from helping them to develop their skills, led to a drastic deterioration in their physical, cognitive and emotional well-being, thus seriously hindering their social inclusion and independent living.
- [438] Violation of the right to education of children with disabilities
- [439] All minors in Tophaus and GGH are of compulsory school age, regardless of their disability. However, the form of compulsory education is already linked to the extent and type of disability. The form of compulsory schooling for a given child is determined by the expert opinion issued by the expert committee assessing the child's learning capacity. Persons with a mild intellectual disability may be subject to an integrated or segregated form of compulsory education, the form of which is proposed by the expert committee. Integrated education means that the child with a disability attends an educational establishment with a normal curriculum, and segregated education means that the child attends a special curriculum, special education establishment, either by attending school or by being a private student.
- [440] A Photo. Article 13(1) emphasises that a person with a disability has the right, inter alia, to early development and care, pre-school education and education in accordance with his or her condition and age, and to receive education and training in

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as defined in the relevant legislation.

[441] Children and pupils with severe to profound disabilities are in a special category of education called 'developmental education'. They receive at least 5 hours of remedial education per week from the age of 5 and then, from the age of 6, they complete their compulsory education in remedial education. Pupils with severe to profound disabilities must attend remedial education until the last day of the school year in which they turn 16. This may be extended until the last day of the school year in which the pupil reaches the age of 23.

[442] Top House

[443] According to the findings of a government office audit cited by the Commissioner for Fundamental Rights, "from 2014, the KLIK should have been providing the development of minors, but only 11 children were being provided with schooling. The educational institutions that should provide travelling teachers have been designated, but pending the inspection, the KLIK has designated 1 teacher." (Ombudsman's report, p. 7).

[444] This means that in 2016, only 11 children out of 49 children completed their compulsory education, but these 11 children were also in the social home, cared for by 1 mobile special needs teacher. The majority of the under-age residents of the Tophaus, 38 children, therefore did not receive any developmental

[445] -was not educated.

[446] House of Providence

[447] The combined expert opinion concludes that access to education for children of compulsory school age has not improved significantly in the GGH. According to the expert opinion, 30 pupils are in segregated education, of whom only 5 attend the educational institution designated by the expert committee on a daily basis. 25 pupils in remedial education are therefore not provided with the quantity and quality of education that would optimally support their development (Joint expert opinion, p. 16).

[448] The combined failure of Defendants VI, IV and VII to act results in the majority of children of compulsory school age not having access to the education to which they are entitled. The combined expert opinion, in our view, erroneously places the responsibility for this solely on the State maintainer of the educational institutions.

[449] As we have already mentioned in detail in our preparatory document of 2 March 2022, according to the practice of the Constitutional Court, "it is the constitutional right and duty of the legislative and executive powers to continuously monitor the operation of the education system, to correct the errors that arise, to remedy deficiencies, to prevent malfunctions and to prevent the system from becoming unworkable." (Report No. AJB-550/2020, p. 10).

[450] The defendant VI. was faced with the fact that the residents of the former Tophaus who were of compulsory school age did not have access to education at the latest when it took over the institution - on 1 July 2018 - and the defendant VI. In addition to the Ministry of Education, which failed to enforce the right to education of the residents of the Tophaus, it did not notify the guardians of the children of school age, nor did it notify the specialised committees responsible for the designation of the institutions.

[451] Right to health and right to health care

[452] In its General Comment No. 6, the CRPD Committee states that "States Parties should prohibit and prevent persons with disabilities from being discriminatorily denied health services. They should also ensure that they are provided with gender-sensitive health services, including sexual and reproductive health rights. States Parties should address the rights of persons with disabilities

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also forms of discrimination that violate the rights of persons by interfering with their right to health by affecting their right to informed and consented health care or by preventing access to facilities or information (CRPD Committee (2018) General comment No. 6 on equality and non-discrimination CRPD/C/GC/6, paragraph 66.)

- [453] Under Article 25 of the CRPD, States Parties recognize that persons with disabilities have the right to the highest attainable standard of health care without discrimination on the basis of disability. States Parties shall take all necessary measures to ensure that persons with disabilities have access to gender-appropriate health services, including health-related rehabilitation. In particular, free and affordable health care of the same scope, quality and standard as that provided to other persons.
- [454] In addition, Article XX of the Constitution states that everyone has the right to physical and mental health. The health care of a person with disabilities must take into account the needs of the person as a result of his or her disability, in accordance with the provisions of the ECHR.[2]
- [455] Pursuant to Article 12 of Act XXVI of 1998 on the Rights of Persons with Disabilities and Ensuring their Equal Opportunities (Act on the Rights of Persons with Disabilities), persons with disabilities shall be provided with regular and effective health care necessary to improve their condition and prevent deterioration of their condition in connection with their disability (...) In the course of health care for persons with disabilities, efforts shall be made to ensure that the care provided promotes their rehabilitation and social integration and does not reinforce their sense of illness.
- [456] On access to public services (including health care), the Fundamental Rights Commissioner underlines that "the principle of equal access means that people with disabilities should be able to benefit from public services of the same quality and quantity as members of the majority society. This requires that public services are organised in a way that takes into account the different needs of different groups of people with disabilities." (Report of the Commissioner for Fundamental Rights in case AJB-550/2020, p. 11)
- [457] In the context of health care, the institution must ensure that residents receive health education, medical care, basic care as required, including personal hygiene, medication, assistance with meals, hydration, changing position and location, continence, and access to specialist or emergency care.
- [458] Pursuant to Article 50 (3) of the Social Welfare Decree, the doctor of the social institution shall ensure regular monitoring of the health status of the beneficiary, medical counselling, screening as defined in the health legislation, prescription of medication and referral to specialised health care if necessary. In all cases, medication shall be recorded on an individual medication record sheet and a numbered event log (handover booklet) shall be kept for each shift of changes and major events affecting the health status of the patient. A record of all cases of sickness, including a record sheet and a logbook. 12(2) of the Fot Fot specifically emphasises the obligation to provide regular and effective health care in relation to the person's disability which is necessary to improve or prevent the person's condition.
- [459] Top House
- [460] The applicant's staff found that many residents, including minors, were abnormally thin. The following photographs taken by the applicant's staff show clear signs of morbid thinness: photos 53, 46, 44, 43, 18,16. There could be several reasons for this, most often malnutrition. Malnutrition is defined as insufficient caloric intake (quantitative starvation) and deficiency of essential nutrients (quantitative starvation).

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which case of malnutrition the defendant's residents are suffering from. Inducing malnutrition (starvation or inadequate food intake) or failing to treat malnutrition that has already developed is an infringement of the right to health and, where applicable, the right to life of the residents.

[461] A 2016 inspection of the Tophaus shows that the residents are not provided with adequate medical care as required by law, which is reflected in the shortcomings of the medical staff and the lack of proper medical documentation. The 2016 maintenance audit found that, although the minimum number of professional staff required by law was ensured, 7 nursing staff and 5 development teachers were not employed (Ombudsman's report, page 11). The maintenance criticised the absence of an adult general practitioner in the institution, despite the fact that the majority of the clients are not children. The audit also drew attention to the lack of proper documentation and hygiene (Ombudsman's report, pp. 12-13).

[462] According to the action plan issued by the defendant IV, the Tophaus is obliged to employ an adult general practitioner without delay (task 13), i.e. the deficiencies identified as a result of the maintenance inspection were not remedied until the issuance of the EMMI action plan.

[463] The complete lack of basic health care and the conditions to ensure access to appropriate specialised care is demonstrated by the fact that on 19 January 2017, the staff of the Commissioner for Fundamental Rights saw a young girl with severe jaw deformity and neglected oral hygiene, who tried to tell us that her face was very painful. MDAC staff found the girl in the same condition during their visits between 15 February and 18 April 2017. It is extremely worrying that the young recipient's medical problem - which was noticeably painful - has not been attended to after 3 months.

[464] During their visits to the site, the applicant's staff met a number of residents who bore signs of some kind of injury. Although the applicant does not know how these injuries were caused, whether they were caused by the residents or staff of the institution or whether they were the result of an accident, it is clear that the injuries are widespread and that they are apparently not being treated and that the safety of the residents within the institution is not guaranteed.

[465] Dental care, lack of oral hygiene

[466] The 2016 maintenance audit already found that several of the beneficiaries were not brushing their own teeth, but using 2 shared toothbrushes instead of the toothbrushes and toothbrush cups that were named for each beneficiary, which were stored separately and locked away in case of an inspection.

[467] Defendant IV's action plan addresses the oral hygiene of residents on several points. Task 14 provides for the organisation of regular dental check-ups for residents no later than 20 July 2017. It follows that the residents have not received any dental health care. Task 15 obliges the respondent I.r. to ensure that the residents' teeth are regularly cleaned using their own toothbrushes. It also follows that the use of the common toothbrush, which was objected to by the maintenance inspectorate, has not ceased and was still in use at the time of the issuance of the action plan of defendant IV.

[468] The applicant's staff observed a lack of oral hygiene in several residents.

[469] In summary, it can be concluded that neither the personal nor the material conditions were given in the Tophaus for the enforcement of the right to health care of the beneficiaries, as the defendants II-IV. In addition, the available evidence shows serious failings in the neglect of the residents' injuries, their morbid thinness and the lack of dental treatment and monitoring.

[470] House of Providence

[471] The joint expert opinion draws attention to the fact that "there is a problem with the usual

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access to and implementation of screening tests" (p. 27).

- [472] Dental and gynaecological check-ups will be highlighted in this section. The expert opinion recognises that "dental screening and treatment on the spot are still to be implemented" and that "appropriate equipment and tools need to be procured... In addition, the expert opinion notes that the beneficiaries do not have non-discriminatory access to health care" (p. 27). (28.o.)
- [473] In the light of the above, it can be concluded that the situation in the institution under investigation in relation to patient care does not ensure equal access to healthcare for the persons concerned, i.e. the rights of the beneficiaries in relation to healthcare are violated.
- [474] Although the expert's statement that the Hungarian state does not create the conditions for adequate health care on a systemic level is true, it cannot be ignored that the legal provisions relating to the right to life and health of the beneficiaries, which are expressly addressed to the defendants, are violated. They are therefore also liable for the omissions.
- [475] g) Lack of access to justice
- [476] Section 7/A (1) of Act XXVI of 1998 on the Rights of Persons with Disabilities and Ensuring their Equal Opportunities (hereinafter: Act No. XXVI of 1998 on the Rights of Persons with Disabilities and Ensuring their Equal Opportunities) states that "persons with disabilities shall be guaranteed equal access to public services, taking into account the different special needs of different disability groups." In the Phot. According to § 4 (fa), access to public services includes "all activities of public authority, including official, governmental and all other administrative and judicial activities."
- [477] And the Equal Treatment Advisory Board in its 2011 Resolution¹ highlighted that "a public service [including access to justice] is accessible on the basis of equality of opportunity if it is accessible to all, in particular to people with reduced mobility, visual, hearing, mental or communication impairments, with appropriate autonomy for the condition of the recipient, in a way that is accessible, predictable, understandable and perceptible." It also stressed that "the provisions on the requirement of equal treatment laid down in specific legislation, such as the Fot., must be applied in accordance with the Ebktv," meaning that failure to "ensure equal access to justice results in a violation of equal treatment."
- [478] The CRPD Convention requires that persons with disabilities, in particular those who are incapacitated, institutionalised, must be provided with legal aid and appropriate legal advice, legal remedies and appropriate support for their enforcement, including through reasonable accommodation and procedural measures/adaptations. The UN Guiding Principles add that persons with disabilities have the right "to free or affordable legal assistance" and "to complain about and take legal action against human rights violations and crimes and to have their complaints investigated and to obtain effective remedies."(UN International Principles and Guidelines on Access to Justice for Persons with Disabilities)
- [479] Top House
- [480] Based on the available data, it can be concluded that the access to justice of the beneficiaries was not guaranteed even during the period of operation of the Tophaus. Neither the local complaints management system, nor the professional care system, nor the representative of the person entitled to care, ensured that all

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access to the justice to which they are entitled. This was partly due to operational dysfunctions within the Top House and partly to systemic reasons.

- [481] The 2015 and 2016 inquiries cited in the Ombudsman's report only touched on the problem, but in our view they provide sufficient evidence of the existence of the violations found by the expert inquiry into the House of Welfare during the time of the Topháza.
- [482] For example, the 2015 investigation of the defendant III.r. itself points out that the representative of the Tophaus did not complain about the violation of the rights of the care recipients in the institution (Ombudsman's report, p. 6).
- [483] The 2015 investigation of the defendant II.r. also called on Tophaus to " The head of the institution and the legal representative of the person entitled to receive care should regularly provide information to the beneficiaries and their legal representatives on the various possibilities of the complaints mechanism. If necessary and requested by the beneficiary, the representative of the beneficiary's rights or, if he or she is not available, the staff of the institution should assist in drafting, describing and sending the complaint to the addressee." (Ombudsman's report, p. 9)
- [484] House of Providence
- [485] In its chapter on the use of legal aid (IV/C. 2.), the joint expert opinion, based on the national report of the ICJJ for 2020, states that "the biggest problem is the violation of the right to information", and the report also shows that in 2020, at the national level, 16 representatives of the rights of the person served received 9,272 requests and complaints related to legal problems.
- [486] In light of this, the statement that the institution "has not received any complaints since 2017"[1] does not support the absence of violations, but the inoperability and apparent inefficiency of the institution's complaints mechanism.
- [487] The experts also agreed that in order to overcome the problems of legal assistance, i.e. to facilitate access to justice for the beneficiaries, it would be necessary and effective to involve authorised legal representatives, legal aid and advocacy organisations (expert opinion, p. 26). In this respect, we would like to stress that the defendant VI consistently refused the assistance offered by the applicant on several occasions and refused to visit the institution despite the applicant's initiatives.
- [488] Also noteworthy is the case of Noémi Rácz, who was refused a power of attorney by the head of the House of Care to provide the applicant with a housing solution, despite the fact that Noémi Rácz had clearly and verbally expressed this need to the applicant and the House of Care (Steven Allen's statement, Record No 102, p. 6).
- [489] With regard to access to justice, the expert opinion also draws attention to the fact that ensuring effective access to justice is questionable
"particularly for service users in residential institutions (...) This is due, among other things, to the fact that the persons concerned have no or only partial access to information on their rights" (p. 26).
- [490] In its case law (Kfv. 37.160/2021/7 [23]), the Curia points out that "in the context of the provisions of the Fot. cited above, the addressee of the active duty to act is essentially the State and, indirectly through it, the providers of public services." A social institution providing personal care which is not maintained by the State, namely the House of Care, which is maintained by the defendant in Case VI, is also a provider of public services and therefore has an active duty to act in ensuring compliance with the provisions of the Phot.
- [491] On the basis of the above, the defendant VI, by failing to comply with its active duty to act - by failing to ensure that equal access to justice for the persons served was guaranteed in the institution - infringed the requirement of equal treatment

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is committing an infringement in breach of.

[492] As a legal argument, he appealed to those below:

[493] breach of the requirement of equal treatment:

[494] According to Section 4 of the Equal Treatment Act, the requirement of equal treatment

[495] a) the Hungarian state,

[496] (c) bodies exercising public authority,

[497] h) persons and institutions providing social, child protection and child welfare services,

[498] (m) budgetary bodies other than those referred to in points (a) to (l) shall be required to observe in the establishment of their legal relations, in their legal relationships, in their procedures and in their actions (hereinafter together referred to as "legal relations").

[499] According to Article 4 of the Equal Treatment Act, the defendants are therefore obliged to apply the requirement of equal treatment in all their existing measures. This means not only refraining from discrimination, but also that they are obliged to take active action to enforce the prohibition of discrimination in the areas within their competence which are contrary to the existing requirement of equal treatment. This general obligation to act actively can be derived from the case-law of the Curia and formerly of the Supreme Court, as well as from the case-law of the European Court of Human Rights in racial discrimination cases.

[500] In the Kaposvár segregated school case, the Supreme Court found the Municipality of Kaposvár, as the school's owner, responsible for "failing to fulfil its obligation of integration, tolerating and maintaining the situation that has developed in the school in question as a result of spontaneous segregation. This omission constitutes the provision required by Article 10(2) of the Ebtv, which establishes the defendant's liability." (Supreme Court Pfv. IV.21.568/2010/5 of 24 November 2010).

[501] As can be seen from the above, all defendants are subject to the personal scope of the Equal Treatment Act, and the requirement of equal treatment must be applied in all their actions (in the case of defendant VI in the context of social benefits). It also follows, in his view, that certain provisions of sectoral legislation which are set out in the legislation designating the duty to carry out checks in the case of each defendant in relation to the frequency, purpose, content and legal consequences of the checks must be read in conjunction with the general anti-discrimination duty contained in the Equal Treatment Act.

[502] The applicant relied on two different forms of discrimination, on the one hand, direct discrimination based on disability as a protected characteristic under Article 8(g) of the Equal Treatment Act and, on the other hand, direct discrimination based on disability as a protected characteristic under Article 10(c) of the Equal Treatment Act.

(1) harassment under paragraph.

[503] All the former and current residents of the Topház and the Gödi Gondviselés Háza have the protected characteristic (disability) as defined in Section 8(g) of the Ebktv. The infringements of rights as disadvantages listed in detail in the application must have been suffered by them because they are residents of the Topház and the Gondviselés Háza, i.e. all the disadvantages are connected with their disability and their placement in an institution closely linked to it.

[504] In relation to comparability, in his view, the hypothetical comparison applies, which is also possible under Section 8 of the Equal Treatment Act, which states that in order to establish direct discrimination, it is sufficient to prove that the aggrieved party is treated less favourably than another person or group in a comparable situation would be treated because of a protected characteristic. Given that both the Tophaus and the House of Providence are exclusively

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cared for persons with disabilities, thus conceptually precluding the identification of a group that would be in a situation comparable in all respects to that of persons residing in institutions, except for the protected characteristic. Therefore, according to the applicant, anyone who is not a resident of the Tophaus or the Gondwangenhaus should hypothetically be considered to be in a comparable situation.

[505] The disadvantages suffered by the persons represented by the applicant, or the imminent risk of such disadvantages, are clearly causally linked to their disability and their institutionalisation. No resident could have suffered any of the disadvantages listed in the application if he or she had not been disabled and could not therefore have been a resident of the institution complained of.

[506] All the defendants sought the dismissal of the action, and all the defendants argued primarily that, in their view, it is precisely in the light of the above that the legislator intended that NGOs should be entitled to pursue claims in the public interest only in exceptional cases, namely in cases where the infringement or imminent threat of infringement affects a large group of persons who cannot be precisely identified and for whom the organisational guarantees cannot be adequately enforced or the enforcement of individual rights is not ensured. This is not the case here. In this context, reference was also made to the consistent practice of the courts, according to which, by virtue of its place and role in the legal system, the litigation of personality rights is not a forum for the resolution of other disputes and cannot serve as a general or special legal remedy. The court in a personality lawsuit has no statutory possibility to give a professional opinion on a dispute that belongs to another procedure (cf. BDT2011.2953)

[507] They therefore sought, first, an order that the proceedings be brought to an end and, second, dismissal of the action on the ground that the applicant lacked standing.

[508] In connection with the defendants' request for termination and the lack of standing, the plaintiff argued that:

[509] The number of persons affected by the infringements at issue in the period covered by this action cannot be precisely determined. The period covered by the application is more than 14 years. The types of discrimination (harassment or direct discrimination) and the facts of the case also vary considerably. The Tophaus is a large institution whose staffing levels can only be considered stable at any given time, due to natural fluctuation and mortality.

[510] Thus, for example, it is already clear from claim 1 that it is not possible to determine exactly how many people have been subjected to indecent and degrading washing, i.e. how many people have been forced by the defendant institution to lie naked on the floor and wait with others to be showered (sometimes with cold water) by the carers over the last 14 years. That the procedure existed is confirmed by the Ombudsman's report.

[511] It is also not possible to reconstruct the exact number of beneficiaries who were not habilitated and rehabilitated during the period of the litigation, as the specific needs of each person are very different due to their disability, health, abilities and interests, and the range, composition and needs of the residents necessarily changed over the 14-year period. On the other hand, there is documentary evidence of a breach: "Both the maintenance inspection in 2016 and the Ombudsman's investigation in early 2017 clearly established that the "mental health activities in the institution are not suitable for restoring and maintaining the physical and mental functions that are absent or limited."

[512] The infringements affecting the residents, as detailed in the application, are documented, solely by the

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it is uncertain exactly who (by name) and how many people were affected by the various infringements during the long litigation period. The present case is a textbook example of public interest litigation, since the infringement is not uncertain, only the size of the affected persons.

- [513] In the alternative, it argued that the applicant's legitimacy in the action exists irrespective of the possible definition of the persons with protected characteristics. According to the applicant, a distinction must be drawn between the fact that it is indeed possible to determine how many disabled persons were present in the Tophaus on a given day during the period in question and the exact number of persons with protected characteristics who were injured on a given day within the scope of the action. The latter circumstance cannot be precisely determined.
- [514] He submitted that the Curia considered the applicant's NGO's application for review to be well-founded and ruled that the applicant also had the right to bring an action in the public interest on the basis of a cumulative disadvantage, which, according to the judgment, was to be considered an essential characteristic of personality. It cited the decision of the Curia, stating that it shared the reasoning of the Curia, already clarified in the applicant's application for review, that the group of children concerned by the case also had the right to bring an action in the public interest on the basis of their financial situation, as the court had explained in its judgment Pfv.20.037/2011/7. Social origin and property status are social determinants in which an individual defines his or her relationship to the world around him or her and his or her place and role in it.
- [515] He also argued that, in his view, the introduction of public interest litigation would facilitate action against the serious infringements of the essential character of the personality of the large number of persons concerned, which have been the subject of the litigation for a long time. Public interest litigation offers legal protection to victims without the need to bring proceedings against the specific persons concerned.
- [516] In the present case, the public interest litigation is presumably the only means of legal protection for many of the beneficiaries, after the plaintiff unsuccessfully tried to contact the professional guardians in order to provide free legal representation to the beneficiaries. The Dunakeszi District Office of the Pest County Government Office refused to disclose the names and contact details of the professional caretakers of the persons whose dependants live in the Tophaus. The applicant has brought an action for refusal to disclose information in the public interest, which is pending. Without the professional guardians, the plaintiff, even if admitted to the Tophaus, cannot legally obtain a power of attorney from the incapacitated beneficiaries. This lawsuit is therefore the only opportunity for the plaintiff to seek redress for the serious legal injuries to the residents of the Tophaus as set forth in the complaint.
- [517] On the other hand, the only legal protection available to the persons concerned seems to be the present public interest litigation, since, simply because of the conflict of interests, it cannot be expected that the professional guardians themselves will bring proceedings against the care conditions and other infringements of which they have been aware for a long time and against which they have done nothing for a long time, and thus their liability for failure to act also arises.
- [518] As stated above, the purpose of public interest litigation is to secure action on behalf of people like those living in Tophaus who are vulnerable and isolated from the outside world. In their view, this interpretation of the law is the only one that is consistent with the spirit of the ECFR.
- [519] First of all, with regard to the defendants' substantive counterclaim, the court emphasises that the decision on the legitimacy of the litigation is a substantive issue on which the court can only rule by judgment, and therefore it can be concluded that the defendants' application for a stay is procedurally unfounded, and the court must therefore decide

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did not rule separately, but decided on the merits of the question of legitimacy in the case.

- [520] Paragraph (1) of Article 20 of Act CXXV of 2003 on Equal Treatment and the Promotion of Equal Opportunities provides that a prosecutor, a public authority or a civil interest organisation may bring an action for the enforcement of a right of personality, an employment action or a public service action before a court for violation of the requirement of equal treatment, if the violation of the requirement of equal treatment or the imminent threat thereof is such that the violation of the requirement of equal treatment is not covered by Article 8. § 8, which is an essential characteristic of the personality of an individual person, and the infringement or imminent threat thereof affects a larger group of persons who cannot be precisely defined.
- [521] Article 8 of the said Act regulates discrimination, according to which direct discrimination is deemed to be any provision which has as its result the actual or perceived a) sex, b) race, c) colour, d) nationality, e) ethnicity, f) mother tongue, g) disability of a person or group, h) state of health, i) religious or philosophical beliefs, j) political or other opinions, k) marital status, l) maternity (pregnancy) or paternity, m) sexual orientation, n) gender identity, o) age, p) social origin, (q) financial situation, (r) part-time or fixed-term nature or duration of his/her employment or other employment relationship, (s) membership of an interest group, (t) any other position, characteristic or attribute (hereinafter together referred to as: characteristic), is, has been or would be treated less favourably than another person or group in a comparable situation.
- [522] From the above, it can be concluded that there are several conjunctive conditions for the assertion of claims in the public interest. It is conditional upon the bringing of a personal, employment or public service action before a court for breach of the requirement of equal treatment. The law specifies which persons or organisations may bring such public interest litigation. These include the public prosecutor, public authorities and interest representation organisations. A further condition for bringing a claim is that the breach of the requirement of equal treatment, or the imminent threat thereof, must be based on a characteristic as defined in Article 8 which is an essential feature of the personality of the individual and that the breach or imminent threat thereof affects a larger group of persons who cannot be precisely defined.
- [523] The court examined whether the above conjunctive conditions could be established in relation to the plaintiff's action. The court found that the conditions set out in Article 20(1)(c) were met by the plaintiff as a civil interest organisation.
- [524] The court also found that the plaintiff had brought an action on the grounds of breach of the requirement of equal treatment in the interests of the residents of the Tophaus.
- [525] The court could also find that the violation of the requirement of equal treatment, or the imminent threat thereof, was based on several of the characteristics set out in § 8. Such as § 8 (g) (h) or even (q) or (t), i.e. disability, health, property and other situations, the plaintiff was entitled to bring the action.
- [526] The court also examined whether these qualities could be assessed as an essential feature of an individual's personality and found that they could.
- [527] It was also established that the infringement or the imminent threat of infringement affected an indeterminate larger group of persons.
- [528] The court did not accept the defendant's argument that the number of residents of the Tophaus could be clearly established from the register and that the lack of a legal precondition therefore precluded the plaintiff's legitimacy. There is no doubt that the number can be determined. Nevertheless, the number of actual victims of each infringement cannot be established with the benefit of hindsight. The applicant has brought his action for a period of more than 14 years, but if

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shorter period, it can still be said that the actual victims of some of the infringements referred to in the applicant's application are manifestly unprovable and their number cannot be established.

[529] Thus, the court found that all the conjunctive conditions of Article 8 were met in relation to the plaintiff, and therefore held that the plaintiff had standing and was entitled to bring an action in the public interest in respect of the occupants of the former Tophaus.

[530] On the merits, too, the defendants moved to dismiss the action.

[531] Defendant II maintained its claim that the plaintiff lacked standing. In addition, it referred to the judgment of the Curia No. Pfv.IV.21.186/2022/10, which, in its view, is also applicable in the present case. In that regard, he submitted that the defendant in the proceedings which formed the basis of the decision of the Curia in Pfv.IV.21.186/2022/10 was the defendant in the present case.

[532] In the case in question, the plaintiffs claimed that their substantive right asserted in the action - the right to human dignity, the right to private and family life, the right to communicate and the right to equal treatment - was based on the provision of the Civil Code guaranteeing the general protection of the rights of the individual. In asserting that right in the action, the applicants relied on the facts that the defendants I and II were under a statutory obligation to provide certain social benefits to which they would otherwise be entitled. The plaintiffs' right to the social benefits of their choice and the alleged failure to comply with the statutory obligation of defendants I and II together, according to the application, amounted to a violation of their various rights of personality. They requested the cessation of the injurious situation by providing the applicants in the territory of B. with subsidised housing in accordance with international professional standards and the obligations undertaken in international conventions ratified by Hungary, enabling them to reside permanently in the territory of B., and until the injurious situation is ceased, with the services provided for in Article 75(1)(b) to (d) of the Social Act at their own expense.

[533] They asked the court to order the defendants jointly and severally to pay HUF 5 000 000 in compensation for non-material damage to each of the applicants.

[534] According to the interpretation of the Curia, the subjective entitlement to social benefits and the violation of the rights of the individual based on this cannot be derived from the Fundamental Law, and therefore certain social benefits cannot be enforced in the context of a personal lawsuit, because the provision of these benefits requires action only on the part of the state, which is implemented in public law relations. Consequently, social benefits cannot be included within the scope of the rights of the personality which may be enforced in civil law proceedings. 1:1, and therefore the adequacy and availability of the various forms of benefits cannot be called into question in the context of an action under the law of personality in general, without regard to the procedural rules.

[535] The relevant finding of the decision of the Curia in the present case is that the general administrative activity of the General Directorate for Social Affairs and Child Protection II, as defined by law, does not in itself cause a violation of the right to personality, and no legal action can be brought on this basis in a personality lawsuit, since "[the] Civil Code. Paragraph 2:51(2) of the Civil Procedure Act does not authorise the court in civil proceedings to order the state executive bodies to take specific measures within the scope of their duties generally defined in sectoral legislation - by pleading omission - which fall within the scope of public law,

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to provide a specific social benefit" (Reason [80]).

- [536] The right to social assistance "[...] is a constitutional right which entails a statutory obligation on the part of the State to regulate and which the State grants in the light of its economic capacity at any given time; the conduct of the defendants, as executive organs of the State, which is the subject of the action, is not protected by the right to protection of personality; the failure of the defendants, who exercise public authority, to perform their public duties or to carry out their general administrative activities, as alleged by the plaintiffs, does not give rise to a relationship of personality in the absence of a direct relationship between the parties; therefore, the condition for the protection of personality is not satisfied. Consequently, the court seised in civil proceedings, acting under civil law, has no jurisdiction, in the absence of statutory authority, to order the defendants to take measures in the field of public law" (Reason [83]).
- [537] The applicant claims that the defendant II. infringed the right to equal treatment of disabled persons accommodated in the Tophaus, which was under its care, by failing to comply with Section 92/B.
- (1) paragraph 3 (1) (b) and (d), Article 3 (1) (n) and Article 4 (4) (a) of Government Decree No 316/2012 (XI. 13.) on the Directorate-General for Social Affairs and Child Protection, and Articles 41-43 of EMMI Instruction No 13/2017 (III. 31.) on the Organisational and Operational Rules of the Directorate-General for Social Affairs and Child Protection, i.e. it complains of failure to fulfil its public law duties. Contrary to the applicant's view, there was no direct legal relationship between the defendant II and the residents of the institution which it maintained.
- [538] In its decision, the Curia stated as a matter of principle that the need to ensure access to a form of social assistance cannot in itself be the basis for the protection of personality. The failure of the defendants, acting as executive organs of the State in the performance of their public duties, as alleged by the applicants, does not give rise to a relationship of personality.
- [539] In the light of the above, the findings of the decision of the Curia are also applicable in the present case, according to which the failure of the defendants exercising public authority to perform their public duties or in the course of their general administrative activities, as alleged by the plaintiff, does not give rise to a personality relationship in the absence of a direct relationship between the parties; thus, the condition for the assertion of a claim for the protection of personality is not fulfilled. The applicant's action is therefore also unfounded on this ground.
- [540] He further submitted that the defendant II had not failed in its duty to inspect. In that regard, the defendant II also contested that it had maintained the institution by failing to fulfil its duty to monitor during the period specified in the application.
- [541] He referred to the fact that the provisions of law relied on in connection with the defendant's failure to act, as set out in the applicant's latest amendment to the application, are summarised below:
- [542] Pursuant to Section 92/B (1) (b) and (d) of the Social Act, the state maintainer of a social institution providing personal care shall monitor the legality of the operation of the institution and shall monitor and evaluate the effectiveness of the professional work once a year.
- [543] Government Decree 316/2012 (XI. 13.) on the Directorate-General for Social Affairs and Child Protection 3.
- According to § (1) n), the Director General shall enforce and, with methodological assistance, shall enforce the requirements for the performance of public tasks and the requirements for the regular and efficient management of resources (in particular: appropriations, staff and assets), and shall monitor and control the enforcement of these requirements. Pursuant to Section 4(4)(a), the branch office is responsible for the implementation of the provisions of Section 92/B(1)(b) to (h) of the Social Act and of the Social Welfare Act. 104 (1) (c)-l) of the Law on the Maintenance of the Family.
- [544] The Rules of Procedure of the Directorate-General for Social Affairs and Protection of Children

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In Articles 41-43 of EMMI Instruction No. 13/2017 (31.III.), the control obligation is reflected in the fact that the control system of the Directorate-General is implemented through the rules and methods defined in the legislation on professional content, the Law on Public Finance and the implementing decree, as well as through the internal control system, of which internal audit is a part.

- [545] This EMMI instruction, to which the applicant refers, was in force from 31 March 2017 to 26 February 2021, i.e. for only part of the period specified in the application.
- [546] On the basis of the above legal provisions, it can be established that the control obligation of the defendant II. extends to the lawful operation of the institution, the annual evaluation of the effectiveness of the professional work and the control of efficient management. The precise method of control is not specified in those rules.
- [547] The applicant identified the alleged failure to act between 27 January 2004 and 30 June 2018 as the time of the infringement, while the defendant II based its liability on its capacity as the institution's maintainer. However, in its observations of 2 March 2022, the defendant claims that the defendant II had exercised the maintenance rights over the institution since 2012 and that the succession took place on 30 June 2018. In relation to the Topház Unified Social Institution, the defendant II, in its capacity as a legal and professional inspector [Act No. 92/B Paragraph (1) (b) and (d) of Section 92/B (3) of the Social Act and Section 100/A of the Social Welfare Act]. This failure to act covers the application of restrictive measures, education, employment, health care and access to justice.
- [548] It is not clear from the applicant's submissions on what he based the starting date of the period of default on. The applicant itself has stated that the defendant defendant II was the operator of the institution concerned from 2012 until 30 June 2018. In the light of the foregoing, it is our view that only that period can constitute the period at issue in the present action II. r., the assessment of his liability cannot cover the period prior to that.
- [549] Furthermore, it can be noted that the findings of the investigations conducted in Topház were based on the report of the Commissioner for Fundamental Rights No AJBH/257/2017 of May 2017, which states that the former maintainer of Topház was the Municipality of Pest County. The staff of the Commissioner for Fundamental Rights carried out an on-site inspection of the institution on 19 January 2017. The report refers to the inspection of the 2nd defendant in 2015 and 2016. In other words, it follows from this that Respondent II carried out inspections in the institution under his care and, on the basis of the information available, suspended the head of the Tophaus with immediate effect and reported on the measures taken in a letter to the Ministry of Human Resources dated 21 July 2017.
- [550] For the period prior to that date, the applicant has not provided any information on the basis of which it could be assumed that the personal rights listed in the application for an amendment of the application have been infringed.
- [551] Based on the statement made by the applicant's legal representative and the testimony of the witnesses heard during the proceedings, it can be established as a fact that no on-site visit was made by them to the Tophaus before 15 February 2017, the applicant's legal representative was not present at the Tophaus until 15 April 2017.
on the 17th day of February 2017, Kristóf Környei witness on the 15th, 17th and 27th days of February 2017 and on the 9th day of March 2017, and Mária Herczog witness did not visit the Topház at all, she only based her statements on the report about the Topház prepared by the applicant, so her testimony cannot be evaluated as evidence. The expert opinion obtained in the case also does not concern earlier years, as it only examined and could only examine the current situation.
- [552] On the basis of the above, it can be concluded that the institution's control obligation

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the maintainer of the property, which was the Municipality of Pest County until 2012 and then the defendant II. until 30 June 2018, therefore it cannot be charged for the period specified in the application

Defendant's Class II Default. In addition, the documentary evidence also establishes that Defendant II conducted inspections in 2015 and 2016, and therefore, regardless of the findings of those inspections, the portion of the complaint that Defendant II failed to comply with its inspection obligations is also without merit. Consequently, it cannot therefore be held liable on the ground of infringement of personality rights.

[553] On the basis of the foregoing, it asked the Court to dismiss the action and order the applicant to pay the costs.

[554] Defendant III also sought dismissal of the action against it in its entirety on the merits.

[555] He also asked the court to order the plaintiff to pay the costs of the proceedings of defendant III. Pursuant to Article 3(3) and Article 4(1) of IM Decree No. 32/2003 (VIII.22.) on the attorney's fees to be assessed in court proceedings, the total amount of HUF 120,000 for the participation in hearings and the number of pleadings.

[556] He submitted that, in the area of failure to supervise, the applicant's action against defendant III sought a declaration that defendant III had failed to comply with the necessary duty to supervise.

[557] In this regard, it pointed out that the defendant III had repeatedly demonstrated its compliance with the statutory provisions imposing the duty to control in the litigation. In its submission of 7 March 2018, it provided documentary evidence of the inspections carried out in 2017. In his submission of 20 January 2020, he provided details of the legal provisions relating to the provision of social services and child welfare and protection services. In its submission dated 20 May 2020, it provided details of its inspections in 2015, 2017, 2018 and 2019, supported by documentary evidence.

[558] On page 35 of its application for final judgment, the applicant indicates the legislation which contains the obligation to carry out the inspection and the timing of the inspection. In that connection, however, it has set out its legal position in its pleadings already mentioned, in particular in its pleading of 20 January 2020. According to which, on balance, it can be said that a home or residential care service for disabled persons covered by the Statute does not automatically qualify as a home care service if it receives minors.

[559] The Social Department of the Department of Guardianship and Justice of the Pest County Government Office (hereinafter referred to as the Government Office) is responsible for the licensing (registration in the provider registration system) and control of basic and specialised social services in the county, based on the provisions of Government Decree 369/2013 (X.24.) on the official registration and control of social, child welfare and child protection service providers, institutions and networks.

[560] The register of service providers is a public register of operating social institutions, which contains the data specified in Act III of 1993 on Social Administration and Social Services (Act on Social Administration and Social Services) and Act XXXI of 1997 on the Protection of Children and the Administration of Guardianship (Act on the Protection of Children and the Administration of Guardianship).

[561] The Government Office draws up an annual inspection plan, on the basis of which the staff of the Social Welfare Department inspect the provision of services by the licence holders during a specified period (normal inspection) or, on request, by means of an exceptional inspection.

[562] The Government Office draws up its inspection plan on the basis of the services registered in the register of service providers.

[563] The Pest County Tophouse run by the Directorate-General for Social Affairs and Child Protection

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Unified Social Institutions did not have a registered Home Service, so the social service was examined in the context of the rules on minors and the provision of services to minors. The Government Office examined the licence holder 1 time in 2015. It carried out 3 inspections in 2017 and 2 inspections in 2018 and 2019, in the course of which it verified that the lawfulness of the care was ensured and that the licensee had complied with the conditions laid down in the official notice.

[564] Defendant III also pointed out that the applicant had not indicated in its application the dates on which it considered that the defendant III had failed to fulfil its duty to monitor.

[565] He referred to the fact that during the evidentiary proceedings, the defendant III. had described in detail in several documents when he had carried out checks. In contrast, the applicant did not indicate the dates on which it considered that the defendant III had not carried out the checks, although, according to the applicant, it should have done so. More generally, the applicant submits that the Court cannot say that defendant III failed to comply with its obligation to carry out inspections, since it has described in detail the inspections it carried out in several pleadings. The applicant's claim cannot therefore be regarded as a precise and unequivocal request. As regards the duty to carry out checks, the applicant's application contains general allegations which are not capable of forming the basis of a judgment upholding the action.

[566] He also pointed out that the applicant had repeatedly referred to the inspections carried out by the defendant III in his application dated 23 March 2023. It can therefore be concluded that the applicant acknowledges that Defendant III carried out inspections, as it repeatedly refers to them itself, and its application for a general declaration that Defendant III failed to carry out inspections is therefore even more contradictory, as in the meantime the applicant acknowledges that Defendant III carried out inspections.

[567] He submitted that the applicant's application against defendant III. is divided into two periods, one before 30 June 2018 and the other after 1 July 2018. In his opinion, it cannot be said that defendant III. did not carry out an inspection in the period before 30 June 2018, since, as he has already explained, defendant III. carried out several inspections during this period.

[568] He also referred to the fact that the defendant had carried out several inspections after 1 July 2018. As mentioned above, this was also presented during the evidentiary procedure and was attached to the documents PE/SZOC/1709-5/2020, PE/SZOC/1675-5/2021 and PE/SZOC/1603-8/2022 documents proving that the defendant III.r. also carried out inspections in 2020, 2021 and 2022.

[569] In the light of the foregoing, Defendant III contends that the relief sought against Defendant III is without merit.

[570] In the context of the failure to apply the necessary legal consequences, the applicant submitted that, according to its summary pleading, the defendant had failed to apply the necessary legal consequences in its application against defendant III. However, the applicant does not cite in this pleading any provision of law which would have been contrary to the provisions of Article III.

would require the application of legal consequences to defendant III, it does not specify any legal consequences that defendant III should have applied. In that regard, it is also submitted that the applicant's application is unclear and imprecise as regards the failure to apply the necessary legal consequences and therefore does not satisfy the requirement of a claim under the Civil Code. The applicant therefore does not indicate any legal consequence which, in its view, should have been applied but was not. Moreover, in this respect, the defendant stated that the applicant had in fact

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is to be commended, as you yourself describe in the 12th page of your submission that on 27 May 2017 the Government Office prohibited the admission of new beneficiaries to the institution. Thus, the plaintiff admits that, following the inspection conducted by defendant III, he took legal action, i.e., defendant III inspected and took legal action, i.e., he did both III. r., which the applicant contests in its application. His application is therefore also contradictory in this respect and cannot, in the defendant's view, serve as a basis for a judgment upholding the action.

[571] He again referred to his submission dated 20 May 2020, in which he described in detail and documented the measures taken by the defendant III. These were as follows.

[572] In order to protect the rights of the beneficiaries under Act III of 1993 on Social Administration and Social Benefits, the Government Office, by its decision PE/SZOC/1167-17/2017 of 29 May 2017, which became final on 30 May 2017, prohibited the maintainer from admitting new beneficiaries until the institution's lawful operation is restored, until the day the decision became final. By Decision No PE/SZOC/57-2/2018 of the Government Office of 14 February 2018, which became final on 20 February 2018, the registration of the Topház Unified Social Institution of Pest County in the register of service providers was amended to be temporary until 31 August 2018. By Decision PE/SZOC/1755-5/2018 of 29 August 2018, the Government Office extended the registration until 31 August 2019, and then until 31 August 2019.

by Decision PE/SZOC/1684-3/2019 of 29 December 2019, with a view to the steps taken to implement the submitted professional plan, solely in the interests of the beneficiaries, until 31 December 2020.

[573] The provisional effect has remained in force until today, as does the measure prohibiting the institution from taking on new beneficiaries.

[574] Plaintiff's claim that Defendant III failed to conduct an inspection and take the necessary measures is incorrect, as the contrary has been demonstrated in detail in the present litigation, as evidenced by documentary evidence.

[575] It can therefore be seen that the defendant III.r. applied and applies the necessary legal measures before 30 June 2018 and after 1 July 2018. Moreover, the applicant has not indicated which other legal consequence should have been applied by defendant III.r. on the basis of which legal provision. In this respect, the applicant's application does not satisfy the statutory requirements for a precise and unambiguous statement of claim. His claim is also contradictory in this respect, as explained above, and is conceded in substance as regards his own claim.

[576] On page 17 of its application, the applicant states that the Tophaus is obliged to inspect II, III and

IV. r. the defendants failed to exercise their powers and contributed to the maintenance of the infringing situation.

[577] In the light of the above, it is considered that the applicant's quoted allegation is unfounded in relation to defendant III.

[578] In its submission, the plaintiff also describes that "none of the defendants entitled to inspect - defendants III; IV and VII - carried out an inspection in the institution maintained by defendant VI after 27 May 2019, no report was prepared and no such inspection was referred to in the lawsuit. This finding by the plaintiff is incorrect. In its submission of 20 May 2020, defendant III submitted documentary evidence that an inspection had been carried out at the institution on 11 June 2019 and 4 December 2019.

[579] In our submission of 20 May 2020, you described.

[580] On 11 June 2019, the Public Health Department of the Vác District Office of the Vác District Office issued a

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carried out a comprehensive public health, epidemiological and nursing inspection of the institution at the request of the MEP. From the report it can be concluded that the application of restrictive measures was considered to be professionally justified and the documentation was in order.

[581] On 11 June 2019, the Public Health Department of the Vác District Office carried out a comprehensive public health, epidemiological and nursing inspection in the institution in response to a request from the representative of the person entitled to assistance.

[582] The inspection found the facility to be clean, and the clothing and textiles of the staff were in order. With the exception of the renovation work in the institution, the inspection found no public health or nursing shortcomings in the care of the residents.

[583] Furthermore, in our submission of 20 May 2020, we also referred to the fact that in 2019, an on-site documentary inspection and an inspection of the care provided to minors in foster care took place on 4 December 2019. The closure order PE/SZOC/00082-2/2020 was attached to our submission of 20 May 2020.

[584] He showed that Defendant III had conducted audits in 2020, 2021 and 2022.

[585] The applicant states on page 36 of its statement of claim: "We note that the Ombudsman's report, which is repeatedly cited in the case, also made findings in relation to the obligation to carry out checks under Article 36(1)(a) of the III. defendant."

[586] Contrary to the applicant's contention, however, it is our view that the Report annexed by the applicant to the application makes general findings on page 31 of the Report referred to above in relation to the inspection of government offices. Specifically, however, the The defendant III.r. is not named in the text in his view. Furthermore, it is also noted in paragraph 6 of the Report, under the heading "My Measures", that the defendant III.r. was not specifically named there either and that the Commissioner for Fundamental Rights did not make any request in relation to defendant III.r.

[587] As discussed in detail above, Plaintiffs' allegation that Defendant III failed to comply with its duty to monitor and to apply the necessary legal sanctions cannot be sustained, and thus Plaintiffs' request that Defendant III be enjoined from engaging in discriminatory practices is unconstitutional. As shown above, Defendant III does not engage in such practices and has not engaged in such practices at all.

[588] On the basis of the above, it can be concluded that the action for failure to monitor and to apply the necessary legal consequences in respect of defendant III is unfounded. Thus, it is also not established that the alleged failure to act on the part of the defendant III r. maintained the harassment and direct discrimination as alleged in the plaintiff's claims 1. 2.

[589] The defendant III. submitted that the applicant would, in its view, only comply with its legal obligation, namely with point 4(c) of the Equal Treatment and Promotion of Equal Opportunities Act of 2003 (Ebkvtv. 2003, CXXV), if it applied the requirement of equal treatment in all its actions. Furthermore, it cited from the Government Decree No. 369/2013 (X.24.) on the official registration and inspection of social, child welfare and child protection services, institutions and networks, the legal provisions that regulate the possible measures that the body authorising the operation may take in accordance with the findings of the inspection.

[590] He submitted that the plaintiff therefore believes that the defendant III. did not enforce the requirement of equal treatment of the residents and residents of the Göd House of Care by the alleged omission of the plaintiff. He therefore asks the Court to declare that the Defendant III's failure to act perpetuated the harassment and direct adverse dismissal.

[591] In this regard, it referred to the judgment of the Curia in Case IV.Pfv.21/186/2022/10-I and its judgment No 83.

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which states that "the omissions alleged by the applicants in the exercise of their public functions or in the course of their general administrative activities do not, in the absence of a direct relationship between the parties, give rise to a relationship of personality: the condition for the protection of personality is therefore not satisfied."

[592] It also referred to paragraph 88, according to which the Curia states that "The failure of the defendants, acting as executive organs of the State in the performance of their public duties, as alleged by the applicants, does not give rise to a personal relationship."

[593] He submitted that in the present case, the respondent III has a public law duty to control the statutory provisions and to apply the legal penalty and it can be established that the respondent III acts as an executor of those statutory provisions, which can be clearly established to be in the public law domain. There is no direct civil-law relationship between the defendant III and the residents of the Göd Visitation House which would give rise to the claim for the protection of personality sought to be enforced in the present action. In the present action, the defendant III, as the body responsible for enforcement, has a public-law duty to carry out checks and to apply the necessary legal sanctions. In this respect, however, the alleged omission of the plaintiff does not give rise to a relationship of personality, the III. defendant and the residents of the House of Care in Göd.

[594] He referred to the fact that the plaintiff in his pleading stated his position that the Curia judgment referred to could not be considered authoritative in the present proceedings, whereas the defendant in Case III, on the other hand, was of the opinion that the Curia judgment referred to could be considered authoritative in any event. In the action on which the Kúriai judgment was based, the applicants sought a declaration against a Ministry and the Directorate General for Social Affairs and Child Protection that they had infringed their right to equal treatment by failing to ensure that the applicants were provided with a specific social service in Budapest. The Court of First Instance held that the judgment at first instance had found that the defendant had failed to fulfil its duty to control. The factual elements are therefore almost identical to the facts of the present case, according to which the plaintiff also alleges that defendant III failed to comply with the duty to control and, as a consequence, the plaintiff claims that the conduct of defendant III does not meet the requirement of equal treatment. In the judgment cited, the Curia emphasised that the existence of a civil legal relationship between the parties to the proceedings is necessary to give rise to a claim for the protection of personality. In the absence of such a legal relationship, the omission does not give rise to a personal relationship between the parties. It is clear that there is no such civil-law relationship between the defendant III and the residents and residents of the Göd Nursing Home, and that the condition for asserting a claim for the protection of personality is therefore not satisfied.

[595] He submitted that he had repeatedly described in detail in the lawsuit the inspections carried out by the defendant III and the legal consequences applied. According to this, the defendant III could not have caused the violation of the requirement of equal treatment and the harassment and direct discrimination alleged by the plaintiff.

[596] Defendant IV requested that the Court dismiss all of the plaintiff's claims as unfounded and award the plaintiff the costs incurred by the defendant. It requested that the court should assess the costs of the proceedings in accordance with the provisions of IM Decree No 32/2003 (VIII.22).

[597] As part of the infringement finding, defendant IV submitted that in response to the allegations of the report prepared by the Mental Disability Advocacy Center (MDAC) and published on 3 May 2017, the results of the 2016 inspection of the maintenance of the institution by the Directorate General for Social Affairs and Child Protection (defendant II) and the results of the 2017 inspection by the Pest County Government Office (defendant III), defendant IV conducted a comprehensive professional inspection of the institution in the first defendant's institution.

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experts, as well as independent experts (the delegate of the National Disability Professional College, the delegate of the Council of Organisations of People with Disabilities, the delegate of the National Association of Disabled People and the President of the National Association of Autistic People). The inspection focused on the legality, professionalism, efficiency and quality of service of the institution. During the investigation, the minutes and reports of the inspections carried out in the institution in previous years were also reviewed (minutes of the official inspection of the defendant II of 8 April 2015, the inspection report of the Pest County Branch of the Directorate General for Social Affairs and Child Protection of 22 October 2016, the Report of the Commissioner for Fundamental Rights in case No. AJB-257/2017).

[598] On the basis of the above-mentioned investigation report, defendant IV. exercising its statutory management powers, prepared an action plan (hereinafter referred to as the "IV. defendant's action plan"), which summarised the tasks to be carried out, the person responsible for implementation and the deadline for implementation in 30 points. The Respondent IV Action Plan identified the Respondent II as the responsible person for the implementation of the tasks as the institution holder, the head of the respondent institution and the head nurse. (The Respondent IV Action Plan was previously attached as Annex A[2].)

[599] A IV. r. alperesi intézkedési terv végrehajtásának nyomon követése, valamint ellenőrzése céljából IV. r. alperes szakmai szervezeti egységeinek képviselői több alkalommal is helyszíni bejárást tartottak. (A helyszíni bejárási időpontjai: 2017. 09. 11-12., 2018. 02.28., 2018. 03.05.)

As a result of the on-site visit, defendant IV, who is the professional manager of defendant II with the rights to maintain the institution, exercised his powers (right to give instructions, obligation to submit reports) and required defendant IV to submit a written report to defendant II on a regular basis on the status of the implementation of the tasks defined in the action plan of defendant IV. The written reports on the actions taken by the 2nd defendant were sent to the 4th defendant on 20 October 2017 and on 31 January 2018.

[600] It can be seen from the above that the on-site visits of 28 February 2018 and 5 March 2018 were carried out following the written reports made by the 2nd respondent, including the verification of the matters contained therein.

[601] On the basis of the above, the Court found the applicant's claim that, in the context of the maintenance of the alleged infringement of the right to equal treatment, the applicant Defendant IV is guilty of unlawful misconduct in the field of professional management.

[602] On the other hand, defendant IV. did not contest the violations revealed in the investigation report, and used all means at his disposal to eliminate them, using his legal powers.

[603] He informed the court that most of the measures set out in the Action Plan for Respondent IV have been implemented, while the implementation of some tasks is still ongoing.

[604] On the basis of the foregoing, it is of the opinion that no unlawful omission can be established with respect to defendant IV.

[605] In the context of the termination of the infringement, he submitted that, as he also referred to in the interim measure, the Pest County Topház Unified Social Institution was not in compliance with the provisions of Government Decree 2051/2017 (XII. 27.) on the tasks related to the replacement of the Topház Unified Social Institution and the strengthening of the control of the social, child welfare and child protection institutional system. Based on the Decree of the General Directorate for Social Affairs and Child Protection as defendant II, the institution is currently maintained by the General Directorate for Social Affairs and Child Protection, and the Charity Service will ensure the improvement of the quality of life of the disabled persons living in the institution, the enforcement of their rights, the provision of a needs-based approach and community-based services by replacing the places.

- [606] The change of ownership of the Göd institution was scheduled to take place in 2018, after which the replacement could begin. The financial coverage of the replacement by the new operator, the Charity Service, was provided by the state with HUF 1,891,400,000 of domestic budget resources. He stressed that the change of the maintenance provider was not motivated by recent events, as he had explained earlier, but was part of the implementation of the professional concept of the past years. The new operator is responsible for replacing the places in the defendant institution, i.e. closing it down, the deadline for which was 31 December 2020. In order to ensure the smooth implementation of the change of ownership, the defendant set up a working group. In the context of the transfer, Defendant IV's explicit objective was to eliminate, as far as possible, the infringements and shortcomings already identified and to establish a form of care that better served the interests of the beneficiaries. The Government's decision to hand over the property made it possible - with the expenditure of some HUF 1.8 billion of additional domestic resources - to replace the institutional environment which was partly responsible for the violations and deficiencies and to provide residents with care better suited to their individual needs within the framework of supported housing.
- [607] In addition, he submitted that, pursuant to Article 66(1)(30) of Government Decree 182/2022 (24 May) on the duties and powers of the members of the Government, the Minister of the Interior is the member of the Government responsible for social policy.
- [608] It referred to the fact that, pursuant to Article 93 of the Government Decree, the Minister, in the framework of his responsibility for social policy, prepares legislation on the situation of disabled persons and persons with reduced capacity for work, on ensuring equal opportunities, on employment, on support for persons and their employment, and on services to ensure independent living for disabled persons, on social benefits in cash and in kind and on social services. The Minister, in the context of his responsibility for social policy:
- [609] a. define the system of professional supervision in the fields of social policy, the system of social institutional care and services, and the directions and tasks for their development,
- [610] b. performs public tasks related to the employment and support of disabled persons and persons with reduced working capacity, and is responsible for employment rehabilitation,
- [611] c. coordinate the implementation of the European Social Charter and international conventions in the interests of people with disabilities.
- [612] Pursuant to Paragraph (3) of Article 194 of the Government Decree, in respect of the functions and powers transferred to the Minister under this Decree - including other functions, entitlements and obligations relating to benefits - the succession shall be governed by the provisions of the Kit. Section 20(5).
- [613] Pursuant to Paragraph (5) of Article 20 of Act CXXV of 2018 on Government Administration, the successor of the ministry headed by the minister who previously exercised the functions and powers shall be the ministry headed by the minister who has assumed the functions and powers, with regard to the functions and powers transferred to the minister on the basis of a decree issued by the Government on the basis of its original legislative powers.
- [614] Pursuant to Section 194 (4) a) of the Government Decree, the succession pursuant to Section 194 (3) of the Government Decree shall also include the property rights and liabilities related to the transferred tasks.
- [615] He submitted that, in his view, in view of the succession of responsibilities for social policy under the Government Decree, the functions and powers, including all the obligations, including the obligation in the lawsuit, were transferred to the Ministry of the Interior and the Ministry of the Interior as defendant VII.

[616] Defendant V also moved to dismiss the action. He submitted that the functions of the defendant V. r. are defined in Articles 109 to 124/D of Government Decree No. 152/2014 (VI.06.) on the Duties and Powers of the Members of the Government. On this basis, it was not the duty of the Respondent V to control the operation and activities of the Respondent I.

[617] Given that Defendant V. was only in a legal relationship with Defendant II. under the Environment and Energy Operational Programme, Defendant V.'s obligation is determined by Government Decree 4/2011 (28 January 2011), which Defendant V. has fully complied with its obligations under the Decree.

[618] Defendant V submits that the action for declaratory relief against Defendant V is unfounded, given that Defendant V is responsible for assessing compliance with the eligibility criteria set out in the Call for Proposals in relation to the KEOP-2015-5.7.0. A

The compliance with the horizontal criteria (equal opportunities, sustainability) set out in the KEOP-2015-5.7.0 Call for Proposals and its Guidelines for Proposals "Energy efficiency improvement of buildings of high priority in public buildings" was fully taken into account by the Defendant No.V., and the application of the Defendant No.II. also complied with these criteria.

[619] In the light of the foregoing, the applicant's claim for a declaration of infringement against the defendant V. is unfounded, and so is the claim for an injunction. V.

According to the defendant r. r., the defendant r. r. V is not liable for the existence of the situation described in the application, in particular since it has no right of maintenance, authorisation or control over the operation of the defendant r. r. I.

[620] On the basis of the foregoing, he requested that the court dismiss the entire claim against defendant V and order the plaintiff to pay the costs of the action. In this regard, he also referred to Articles 3 and 4 of IM Decree 32/2003 (VIII.22.).

[621] The defendant VI asked the Court to dismiss the applicant's action as unfounded. [622] It submitted that the action did not allege any specific conduct that would constitute a breach of Article VI.

r. defendant, given that the conduct and acts referred to all relate to the defendant I. defendant, which has ceased to exist without legal successor. The applicant does not have any information concerning the operation of the House of Care, which has been operated by defendant VI since 1 July 2018. Nor has the applicant identified in the application any specific acts or conduct carried out by defendant VI since 1 July 2018 which are order the defendant to pay the costs. All it alleges is that it has a reasonable probability that the violations alleged against Defendant I continue to exist to this day as to Defendant VI, based on the facts and evidence alleged against Defendant I.

[623] He submitted that the plaintiff's so-called plausibility in the action against defendant VI is expressed solely in the fact that the social institution established and operated by defendant VI is located on the site of the former institution that was still in operation there at the time the action was brought. He has not provided any information, experience or official checks which would have enabled him to reach the level of probable cause, even though, in this respect, which is not disputed by the defendant in this case, the Brussels I Regulation contains a lighter burden of proof in favour of the applicant than that laid down in the classic rules of procedure. All the reports and official findings relied on by the applicant as evidence or as a basis for probable cause were drawn up during the operation of the former institution and on the basis of that evidence, on the basis of which the applicant merely states that it has no information to suggest that there have been any changes. That statement is now no longer true, not least because, in the context of the professional programme which was also subsequently concerned, the defendant VI provided detailed information on the infrastructural and staffing measures it had taken, including improvements to staffing and the individual needs of residents.

in the way they are treated, their individual needs are identified and adapted in the course of the operation. [624] In view of the above, and also in view of the fact that during the period of the lawsuit the institution did not

an institution with a temporary operating licence, the applicant continues to claim that it has no knowledge of the functioning of the institution and continues to make the implausible claim that nothing has changed in the last two years, and even suggests that the situation has deteriorated. All this in a way that the alleged acts are not in line with the previous I.

r. against the defendant has neither been proved nor established by a court, i.e. the VI.

the charges against defendant r. are alleged infringements based on alleged infringements.

[625] He submitted that he agreed with the expert opinion obtained by the court. The following made additions to this round.

[626] As correctly described in the expert report, the provision of the education necessary for the residents to fulfil their compulsory schooling is not the responsibility of the VI Defendant. It is the responsibility of Defendant VI to ensure the availability of educational institutions or to receive travelling teachers, whereas it is the responsibility of the parents or guardians to enrol the resident in the case of compulsory education. In addition, the defendant VI, despite the fact that the school-age children who were admitted to the institution had valid expert reports, requested that each minor be re-examined by an expert in order to ensure that he or she was admitted to an educational establishment appropriate to his or her condition and ability. The defendant VI is not responsible for the method and quality of the educational activities of the host institutions.

[627] He referred to the fact that he does not dispute the report's expert findings concerning the professional therapeutic professionals, but it must be emphasised that the operation of the defendant institution also complies with the legal requirements in this respect, given that all the therapeutic staff employed have higher education qualifications that comply with the provisions of the Act No. 1/2000 of 7 July 2000 on the professional duties and conditions of operation of social institutions providing personal care..) of the Ministry of Social Affairs and Labour, which sets out the minimum qualification requirements for the position of therapist in personal care social institutions.

[628] With regard to health care, he added: The defendant institution is not a health care institution but a social institution, and therefore does not provide general and specialised health care services. However, as stated in the expert report, it fully complies with its legal obligations to ensure permanent medical supervision of residents and makes every effort to ensure access to specialised and regular screening. However, as stated in the expert report, the screening of persons with severe mental disabilities (ophthalmology, dentistry, specialised screening for women and men) requires special conditions. In some cases, this can only be done under general anaesthesia. However, the public health care system is not equipped to deal with these special care modalities. Private health care institutions are not a target group. This leaves the defendant institution vulnerable to systemic deficiencies, both in terms of the possible lack of specialised equipment and the lack of sensitisation programmes involving nearby hospitals and specialist clinics.

[629] In addition to this, the expert report clearly states that the mental and health condition of the residents is adequate, not warranted and no immediate medical screening or intervention is required. In conclusion, he submitted that, in his view, the expert report had accurately and in sufficient depth explored the operation of the defendant institution, correctly concluding that the operation of the defendant institution not only complied with national legislation but also, in many cases, applied unique and forward-looking methodological and practical solutions to improve and continuously improve the living conditions of the residents.

- [630] He submitted that on the basis of the expert's report, it is clear that the defendant VI - ensures the lawful functioning of the institution, neither its methods nor its staff in the operation of its institution give rise to the harassment complained of, does not maintain degrading and humiliating living conditions, does not discriminate against residents, does not restrict the personal freedom of residents, and the restrictive measures applied on a case-by-case basis are in accordance with the law and the principle of proportionality, provides sanitary facilities for residents, is continuously improving its housing environment, is continuously improving its supported housing facilities, and is about to embark on a complete institutional reconstruction, the development programme has a strong emphasis on the habilitation and rehabilitation of residents and the possible use of early development and care methodologies and tools, regardless of age, even though the institution no longer has any residents in the early development and care category (0-2 years), ensure their right to education by providing access to the designated educational establishment for all residents and, for travelling teachers, an appropriate educational environment within the walls of the establishment, ensure the health care of residents with a permanent medical presence and the use of the public health care system for all specialist care needs.
- [631] He also submitted that, in his view, the expert's report contains all the substantive findings that provide a sufficient evidentiary basis for the dismissal of the claims against the defendant VI.
- [632] It further submitted that, contrary to the applicant's submission, the properties renovated by the defendant VI are not residential homes but subsidised housing properties which provide services to each beneficiary according to his or her individual needs. Defendant VI purchased family homes to provide low-income care, which it renovated, modernised and adapted to the needs of the recipients, thus ensuring person-centred support. As the houses were purchased within the surrounding municipalities, community participation of persons with disabilities is achieved.
- [633] He also referred to the fact that on 15 July 2018, the applicant's representatives arrived unannounced at the institution, where they were nevertheless received by the head of the institution in a cooperative manner. They produced a power of attorney bearing the signature of Noémi Rácz, who was said to be totally incapacitated. The legal text of the power of attorney was difficult to interpret, even for a layman, and contained references to several national and European laws. A meeting took place, at which the head of the institution representing the applicants and Noémi Rácz, who was unable to read, were present. The head of the institution read out the text of the power of attorney to her slowly and clearly, Noémi's answer to the question whether she understood what she had heard was no, nor did she remember ever having signed such a power of attorney. During the conversation, it became clear that if he had signed the power of attorney, he did not know what he was signing, as he could not interpret the complicated legal text. It also became clear that Noémi could not have given a power of attorney, either verbally or in writing, to represent him. The applicants' representatives did not ask a clear question as to the content of the representation. Noémi was not informed of their intention, so that there could be no express intention on Noémi's part to grant a power of attorney. In view of this, the head of the institution had understandable doubts as to the authenticity of the power of attorney and did not authorise subsequent contacts, in particular by bypassing the legal representative of the residents, on the basis of this power of attorney.
- [634] He reiterated that, in the context of the applicant's claim, which was based on a physical and mental condition

and needs assessment involves the involvement of an external doctor, that the professional process of eviction includes a complex needs assessment of the residents, on the basis of which an individual service plan is prepared. The defendant has complied with this obligation. The final deadline for completion of the community inclusion process is 31 December 2024.

- [635] He said that the aim of the R.VI. applicant, as confirmed by several external studies, is to provide the residents with care that is appropriate to their abilities, that ensures that they can develop to their potential and live as full a life as possible. However, it would be naïve to think that closing the institution will solve this at a stroke. In all EU Member States, the Gød and similar 'centralised' institutions and forms of care based on micro-community living are operating simultaneously.
- [636] He argued that the applicant refuses to acknowledge that above a certain level of support needs, individuals require a permanent form of care, 0-24 hours assistance, which precludes a form of supported housing based on and enabling a high degree of autonomy and decision-making competence. The applicant's request for the total closure of the institution is unprofessional and would fundamentally infringe the right to human dignity of residents who, because of their high need for support due to their intellectual capacity and/or physical disability, are incapable of organising and managing their own living and self-care, even partially.
- [637] Regarding raised beds with side rails, he said that all hospitals that care for people with limited mobility currently have them, but that the use of a bed with rails for a newborn baby does not result in inhumane treatment. The expert examination carried out in the course of the trial itself concluded that such devices used in the institution are intended to ensure the physical safety of the residents or even to prevent self-harm.
- [638] Regarding the restriction of the personal freedom of the residents, he claimed that he still maintains, as confirmed by the multiple visits he made during the expert's inspection, that there is no cage in the institution. The Commissioner for Fundamental Rights had prohibited its use in relation to the former establishment, not in relation to the defendant VI. Torture, cruel, inhuman, degrading or punitive restraint.
- [639] He argued that a person's personal freedom can be restricted to protect his or her life, limb or health or that of others. He referred to the fact that it is clear from the previous submissions and the expert opinion that the defendant VI applied only and exclusively measures restricting personal liberty in accordance with the legal provisions cited by the applicant.
- [640] He explained that 1 resident has elbow braces because he is vomiting and not even permanently, i.e. he is ejecting for his health. The defendant VI is not familiar with the concept of a restraint blanket and does not use one. With regard to the violation of human dignity, he submitted that the plaintiff's allegation is that 1 toilet in nursing unit A is not working, 1 is displaced and 1 is missing. Used nappies were found on the top of the cupboards. Based on information from 6 years ago, which is no longer correct, there are currently 12 toilets in the facility in good working order.
- [641] According to the applicant, there are extensive soaking marks and wall cracking on the wall surfaces of the bathrooms in Care Unit C. He stated that this unit is occupied exclusively by inpatients who do not use the bathrooms and that it had been covered up pending renovation. The delay in renovation will not affect maintenance.
- [642] He submitted that the personalised care of the care recipients is provided by the defendant VI. With regard to the inhuman living environment of the residents, he submitted that it was correct to state that the condition of the residential rooms in the institution was in order. One corridor of the building (corridor D) has been

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has been closed, and the other corridors are being moved out. A complete renovation of the building is therefore unnecessary. Periodic maintenance works are carried out, but the bathrooms have been renovated despite the fact that a significant part of them became redundant after the replacement of the occupants.

- [643] With regard to the neglect of disabled persons, it was submitted that the shortage of labour after the takeover was covered by the defendant by hiring out labour. Currently, the institution employs staff with the level and professional qualifications required by law, as confirmed by the expert opinion and the Pest County Government Office.
- [644] As regards the neglect of disabled children, the applicant submitted that, according to the applicant, the defendant VI. In the first place, the VI.VI. complained that, at the very latest on 1 July 2018, when the institution was taken over, the defendant was faced with the fact that the residents of the former Tophaus who were of compulsory school age did not have access to education and that it itself had failed to act, in addition to the Ministry responsible for education, by not enforcing the right to education of the residents who were of compulsory school age, by not informing the guardian of the children who were of compulsory school age, and by not informing the expert committees responsible for the designation of the institution.
- [645] He maintained that the provision of education to the children was not an obligation of the defendant VI and submitted that the defendant VI had reported the problem to all necessary fora and competent authorities and had therefore acted with due diligence. With regard to the right to health care, he submitted that the deficiencies in the health care system, as raised by the expert, cannot be held liable by the defendant.
- [646] As regards the right to justice, it argued that the representation of the persons concerned is adequately ensured and the advocacy forum is functioning in accordance with the legal requirements. All the persons concerned have a legal representative and the representative of the person concerned visits the institution on a regular basis.
- [647] The total amount of the costs of the action is HUF 2,460,000 + VAT, as set out in the schedule of costs.
- [648] Defendant VII, as the successor in title to Defendant IV, submitted that all of Defendant IV's declarations remain unchanged. In addition, it relied on the following.
- [649] In its view, the applicant's claim in relation to the EMMI, based on the provisions of Government Decree 152/2014 (VI. 6.) on the duties and powers of the members of the Kornány (hereinafter: Government Decree 152/2014 (VI. 6.) Regulation No. 152/2014), which designated the general sectoral matters falling within the competence of the Minister of Human Resources, and then, in the light of the succession of the proceedings, the provisions of the Minister of the Interior's Regulation No. 182/2022/2014 on the functions and powers of the members of the Government, which, in relation to the defendant in the VIIth instance, laid down the functions and powers of the Minister of the Interior in relation to his sectoral management responsibilities. (24 May 2011), as well as the management powers under Article 9 of Act CXCV of 2011 on Public Finances ('the Áht'), relied on by the applicant in relation to the defendant in the second instance, and the management powers also relied on in relation to the Klebelsberg Centre, are not suitable for establishing an infringement of the right to a fair hearing. In this regard, it relied on the findings of the Curia as the reviewing court in its partial judgment of 5 April 2023, case no. Pfv.IV.21.186/2022/10 (hereinafter: "Partial Judgment").
- [650] In its Partial Judgment, the Curia examined whether there was a civil legal relationship between the plaintiffs and the defendants that could give rise to the asserted claim of personality rights, and whether the possible failure of the Ministry of the Interior I. defendant to exercise its powers of control in the field of legality could constitute a violation of personality rights.
- [651] The Curia explained with regard to the rights of personality that "as a result of its regulation, the Civil Code - like the old Civil Code - is not applicable to the rights of personality. 75.(1) of the old law - protects personality rights in general.

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rights and obliges everyone to refrain from violating them." [Paragraph [62]] "The right of personality is a general legal relationship with an absolute structure, the content of which is binding on all. . . . Legal relationships with an absolute structure are generally transformed into a legal relationship with a relative structure by some obligatory fact. Such a fact may be, for example, a contract, a tort or delict, a violation of a personal, property or other right, a unilateral declaration [Civil Code, Art. 6:2 (1)]. In the law of personality, the relativisation of a legal relationship with an absolute structure is created by the act of violation of a personal right as a specific obligatory event, creating a concrete bilateral obligation between precisely defined persons. The infringement of the right to personality thus creates a legal relationship of relative structure between the infringer and the rightholder, which may form the basis of a civil claim, including a claim for the protection of personality." [Paragraph [63]]

[652] The Curia stated that "According to Article 18 (2) of the Fundamental Law, the Minister shall, within the framework of the general policy of the Government, independently direct the sectors of the public administration falling within his/her competence and the subordinate bodies, and shall perform the tasks specified by the Government or the Prime Minister. Among the general tasks of ministers, the Fundamental Law specifies the management of sectors, organisational management and the implementation of tasks determined by the Government or the Prime Minister. The Minister may carry out his or her activities within the framework of the general policy of the Government, may direct the sector of the State administration falling within his or her remit, may issue decrees on the basis of the authorisation granted by law or Government decree pursuant to Article 18(3) of the Fundamental Law, may act in his or her capacity as a Minister, may issue decrees independently or with the consent of another Minister. Pursuant to paragraph 53 (2) (c) and (d) of Decree No 182/2022 (24 May) on the Duties and Powers of the Members of the Government, the Minister shall prepare draft laws and government decrees, the decisions of the Government, the Prime Minister and the President of the Republic, and shall issue ministerial decrees on the basis of the authorisation of the law or government decree, prepare draft laws for the period of special legal order, and exercise institutional management and supervision." [Paragraph [78]]

[653] With regard to the EMMI, he noted that with regard to the general duties and powers of the Minister in charge of policy, paragraph 20 (1) c) and d) of Government Decree No.152/2014 (6.VI.) contains provisions identical to those contained in paragraph 53 (2) c) and d) of Government Decree No.182/2022 (24.V.), thus the findings of the Curia are also applicable to the EMMI.

[654] In its partial judgment, the Curia ruled with regard to the Ministry of the Interior that "the defendant I. r. performs general public law functions within the framework of the central state administration by developing abstract rules of conduct and by performing institutional management and supervisory tasks, which do not give rise to a civil relationship in the absence of a direct attack on the privacy of the individual. Paragraph 2:51 (2) of the Civil Code does not authorise the court in civil proceedings to oblige public enforcement bodies to take specific measures within the scope of their duties generally defined in sectoral legislation, to provide specific social benefits, on the grounds of failure to act, within the scope of a public law relationship." [Partial judgment paragraph [80]]

[655] In its judgment, the Curia also stated with regard to the defendants, including the Ministry of the Interior, that "the conduct of the defendants as executive organs of the State, which is the subject of the action, is not protected by the right to personality; the failure of the defendants exercising public authority to perform their public duties or in the course of their general administrative activities, as alleged by the plaintiffs, does not give rise to a relationship of personality, in the absence of a direct relationship between the parties, and therefore the condition for the assertion of a claim for the protection of personality is not met. Consequently, the court seised of the civil action, acting under a civil relationship

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has no power to order the defendants to take measures of a public law nature in the absence of a legal authorisation." [Paragraph [83]]

- [656] In its judgment, the Curia stated in principle that "I. The mandatory content of the protection of personality rights is respect for the subjective rights of others. A condition for the enforcement of personality rights is conduct which infringes or endangers the subjective right of personality and which gives rise to a civil legal relationship, including a personality relationship, in the relationship between the party who infringes and the party who suffers the infringement. II. The need to ensure access to a form of social assistance cannot in itself be a basis for the protection of personality rights. In civil proceedings, the court hearing the civil action has no jurisdiction, in the absence of a statutory power, to order the defendants to take measures relating to public law relationships. The failure of the defendants, acting in their capacity as executive organs of the State in the performance of their public functions, to act in accordance with public law, as alleged by the plaintiffs, does not give rise to a relationship of personality." [Paragraphs [87]-[88] of the judgment]
- [657] Based on the partial judgment of the Curia, it is of the opinion that certain provisions of Government Decree No. 152/2014 (6 June 2014), cited by the applicant in relation to the EMMI, which designated general sectoral matters falling within the competence of the Minister of Human Resources, and then, in the light of the succession in the lawsuit, amended the provisions of the VII. the provisions of Government Decree No 182/2022 of 24 May 2022 laying down the duties and powers of the Minister of the Interior in relation to the defendant and the management power under Article 9 of the General Tax Code are not suitable for establishing an infringement of the right to personality in relation to the EMMI and the defendant in the present case. In the light of the judgment in the main proceedings, the aforementioned provisions of the legislation referred to by the applicant regulate the performance of public tasks covering a wide range of persons and do not give rise to a civil relationship in the absence of a direct attack on the personality of the individual. The system of protection of personality under Act V of 2013 on the Civil Code (Civil Code) - and Act IV of 1959 on the Civil Code (old Civil Code) - is therefore not applicable to EMMI and the defendant in Case VII on the basis of those provisions of law. Furthermore, as stated in the judgment under appeal, the court hearing the civil action, acting under civil law, has no jurisdiction, in the absence of statutory authority, to order the defendant to take measures of public law in respect of the obligations sought by the applicant against the defendant VII (summary of the proceedings, page 8, point 6 and page 10, point 8).
- [658] In its view, the applicant's further reference to the failure to exercise the right of control provided for in the grant agreement with defendant VI and in Government Decision No 2051/2017 (27.12.2017) is also incorrect. By Government Decision No 2051/2017 (XII. 27.), the Government decided that the institution would be maintained by the defendant VI, which would ensure that the places were replaced. The State will provide the financial cover for the replacement to be carried out by the defendant VI as the new operator. The EMMI and the defendant VII had and still have the power and responsibility to control the replacement on the basis of the grant contract with the defendant VI. The substantive elements of the conclusion of the grant contract, including the control, are governed by the General Tax Code. This control concerns the legality of the use of the aid. In the absence of a direct link, in the absence of a direct attack on the personality of the individual, the grant relationship does not give rise to a personality relationship, cannot give rise to an infringement of personality rights, and cannot be the subject of an action by the applicant.
- [659] As a claim for costs, he asked the court to order the plaintiff to pay a total of HUF 2,520,000 in costs for 126 hours at an hourly rate of HUF 20,000 + VAT for the defendant VI.
- [660] The defendant VIII applied for dismissal of the action. It submitted that the defendant VIII maintained unchanged all the oral and written statements made by its predecessor in the action. The applicant

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the former defendant I. in 2015 received a grant of 149.981.365,-Ft from the European Union within the framework of the KEOP-2015-5.7.0 Operational Programme for Environment and Energy Efficiency.

- [661] In its original application, the applicant further described that pursuant to Article 10(4) of Government Decree No. 272/2014 (XI. 5.) on the rules for the use of certain European Union funds in the 2014-2020 programming period, the legal predecessor of defendant VIII "shall carry out checks on the organisations and beneficiaries involved in the implementation of the funds to ensure that the European Union development funds are used in accordance with the development policy legislation, in a regular and appropriate manner".
- [662] However, the predecessor of the defendant VIII, the defendant II, was the beneficiary of the grant under the KEOP-5.7.0/15-2015-0246 project, i.e. the beneficiary of the grant contract was the Directorate-General for Social Affairs and Child Protection.
- [663] For the Environment and Energy Efficiency Operational Programme, the member of the Government designated to act as the managing authority for the use of EU funds was the the predecessor in title of defendant VIII.
- [664] The predecessor in title of the defendant VIII did not have any legal relationship with the former defendant I and did not have any legal relationship with the defendant VI.
- [665] On the scope of the Call for Proposals "Priority Energy Performance of Public Buildings" KEOP-2015- 5.7.0, in the Operational Programme Environment and Energy Action Plan 2011-2013, Action 5. The Government decided on the consent to the announcement of the call for priority projects under priority 5 of the KEYERP.5.0, on the pre-nomination of priority projects and on the amendment of the Action Plan of the Environment and Energy Operational Programme for 2011-2013 by Government Decision No. 1290/2015 (5 May 2015), No. 1290/2015 (6 May 2015), No. 1290/2015 (5 May 2015).
- [666] The legal predecessor of the defendant in Case VIII could only examine compliance with the eligibility criteria set out in the call for proposals when awarding the grant, and could not examine other criteria in the selection procedure. The criteria of the call for proposals were II. defendant's application "Energy modernisation of the building of the TOPHÁZ Special Home in Göd", KEOP-5.7.0/15-2015-0246, was successful. Compliance with the selection criteria was verified by the predecessor of defendant VIII.
- [667] The project KEOP-5.7.0/15-2015-0246 was implemented by the Environment and Energy Operational Programme. In that regard, the project KEOP-5.7.0/15-2015-0246 is subject to the provisions of Government Regulation No 4/2011 of 28 January 2011 on the rules for the use of aid from the European Regional Development Fund, the European Social Fund and the Cohesion Fund for the 2007-2013 programming period ('the Government Regulation'), which the legal predecessor of defendant VIII has fully complied with.
- [668] Following the implementation of the project entitled "Energy modernisation of the building of the TOPHÁZ Special Home in Göd", the legal predecessor of defendant VIII. conducted an on-site inspection on 13 June 2016 at the property at 2, Munkácsy M. u. 2132 Göd, and the report of the inspection was submitted to the court.
- [669] The legal predecessor of defendant VIII was only entitled to check that the project had been carried out in a satisfactory manner, which included the following works: thermal insulation of the façade, thermal insulation of the end slab, thermal and water insulation of the flat roof, replacement of the façade windows. According to the on-the-spot inspection report, the predecessor of defendant VIII fully supervised the execution of those works and complied with its legal obligations.
- [670] Given that Defendant VIII's predecessor in title only entered into a legal relationship with Defendant II under the Environment and Energy Operational Programme, Defendant VIII and its predecessor in title

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obligations are defined by the Government Decree, which obligations have been fully complied with by defendant VIII and its predecessor in title.

- [671] The action for a declaration against defendant No VIII is unfounded, since the predecessor of the defendant VIII. r. is responsible for verifying compliance with the eligibility criteria set out in the call for proposals for the KEOP-2015- 5.7.0.
- [672] The application against defendant No VIII in the alternative action, in which the applicant sought only an injunction against defendant No VIII from future infringing conduct, since its predecessor in title had not ceased to exist, was also unfounded, given that defendant No VIII was not currently engaging in infringing conduct and certainly did not intend to engage in such conduct in the future, the abovementioned project having already been completed.
- [673] The compliance with the horizontal policy activities (environmental sustainability, equal opportunities) of the KEOP-2015-5.7.0 Call for Proposals and the Guidelines for Proposals of the Respondent VIII was fully taken into account by its predecessor (point 8 of the on-site visit report), and the application of the Respondent II also complied with these criteria. In the comment boxes under point 8, it is described in detail that the Respondent II has complied with the deficiencies. On the basis of the above, the applicant's claim for a declaration of infringement against defendant VIII is unfounded.
- [674] In the light of the above, he requested the Court to dismiss the claim of the applicant against defendant VIII and to order the applicant to pay the costs of the proceedings. He requested that the costs of the proceedings be awarded in accordance with § 3 and § 3 of IM Regulation No. 32/2003 (VIII. 22.) on the attorney's fees and costs in court proceedings.
§ 4.
- [675] The defendant in Case IX asked the Court to dismiss the action brought against it and to award costs.
- [676] According to the defendant in Case IX, the applicant's action is unfounded.
- [677] The applicant's application against the defendant in Case V seeks a declaration that the defendant in Case V, as the ministry responsible for the management, regulation and control of the development funds, has maintained the harassment and direct discrimination described in the above-mentioned points in breach of Article 10(1) of the Eb-ktv and Article 8(g) of the Ebktv, and that there is an imminent threat of such harassment and direct discrimination in breach of Article 20. § In the context of the project KEOP-5.7.0/15-2015-0246, the defendant, in the second instance, has failed to fulfil its obligation to comply with the obligation to ensure monitoring under Article 5/A(1)(k) of Government Decree No 4/2011 (I. 28.) of 28 January 2011 on the rules for the use of aid from the European Regional Development Fund and the Cohesion Fund for the 2007-2013 programming period.
- [678] He submitted that the subject matter of the action relates to a project financed by European Union funds, as the applicant claims that the former defendant I received a grant of HUF 149 981 365,- from the European Union in 2015 under the KEOP-2015-5.7.0 Operational Programme for Environment and Energy Efficiency. In its original application, the applicant further stated that, pursuant to Article 10(4) of Government Regulation No 272/2014 (5.11.2014) on the rules for the absorption of assistance from certain European Union funds in the 2014-2020 programming period, the legal predecessor of the defendant in Grade VIII "audits the organisations and beneficiaries involved in the implementation of grants to ensure that EU development funds are used in accordance with development policy legislation, and in a regular and appropriate manner". In the action, the defendant in VIII submitted that its predecessor in title had awarded a grant to the defendant in II in the context of the KEOP-5.7.0/15-2015-0246 project, so that the grant contract

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the beneficiary was the Directorate General for Social Affairs and Children, defendant in the second instance. [679] Defendant V was not related to the plaintiff's activities (and thus to the conduct), but for the energy modernisation of buildings, which is not even indirectly linked to the circumstances giving rise to the action brought by the applicant. On

Defendant V, as the sponsor, was only obliged to monitor the use of the aid, while it was neither obliged nor entitled to monitor the activities of the predecessor of Defendant II or Defendant VI. This is evidenced by the documents submitted by the defendant in Case V, the authenticity of which was not contested by the applicant. Thus, the defendant V and, by extension, the defendants VIII and IX, are being sued as parties to the action, on the one hand, without justification and, on the other hand, without any basis in fact.

[680] The defendant IX requested that the court take into account the statements of its predecessors in title as its own

[681] The action is well founded in part as follows.

[682] The court found that the duties of the defendant V. were defined in Articles 109-124/D of Government Decree No.152/2014 (VI.06.) on the duties and powers of members of the Government. On this basis, it was not the duty of the defendant V to control the operation and activities of the defendant I.

[683] Defendant V is succeeded by Defendant VIII.

[684] Given that Defendant V. is only in legal contact with Defendant II. in the context of the Environment and Energy Operational Programme, the obligation of Defendant V. is determined by the provisions of Government Decree 4/2011 (28.I.),

[685] Defendant V is responsible for the examination of the compliance with the eligibility criteria set out in the Call for Proposals in relation to the KEOP-2015-5.7.0 project "Energy efficiency improvement of buildings of high priority in public buildings".

[686] The legal predecessor of the defendant defendant in the VIIIth instance - the defendant in the Vth instance - granted a subsidy to the defendant in the IIInd instance in the framework of the project KEOP-5.7.0/15-2015-0246, so the beneficiary of the subsidy contract was the Directorate-General for Social Affairs and Child Protection.

[687] For the Environment and Energy Efficiency Operational Programme, the member of the Government designated to act as the managing authority for the use of EU funds was the the predecessor in title of defendant VIII.

[688] The court found that the defendant V, as the predecessor in title of the defendant VIII and IX, had no legal relationship with the former defendant I and no legal relationship with the defendant VI.

[689] On the scope of the Call for Proposals "Priority Energy Performance of Public Buildings" KEOP-2015- 5.7.0 under the Action Plan of the Environment and Energy Operational Programme 2011-2013, Action Plan 5. The Government decided on the consent to the announcement of the call for priority projects under priority 5 of the KEYERP.5.0, on the pre-nomination of priority projects and on the amendment of the Action Plan of the Environment and Energy Operational Programme for 2011-2013 by Government Decision No. 1290/2015 (5 May 2015), No. 1290/2015 (6 May 2015), No. 1290/2015 (5 May 2015).

[690] The legal predecessor of the defendant in Case VIII could only examine compliance with the eligibility criteria set out in the call for proposals when awarding the grant, and could not examine other criteria in the selection procedure. The criteria of the call for proposals were II. defendant's application "Energy modernisation of the building of the TOPHÁZ Special Home in Göd", KEOP-5.7.0/15-2015-0246, was successful. Compliance with the selection criteria was verified by the predecessor of the defendant in VIII and IX.

- [691] The project KEOP-5.7.0/15-2015-0246 was implemented by the Environment and Energy Operational Programme. In that regard, the project KEOP-5.7.0/15-2015-0246 is subject to the provisions of Government Regulation No 4/2011 of 28 January 2011 laying down the rules for the use of aid from the European Regional Development Fund, the European Social Fund and the Cohesion Fund for the 2007-2013 programming period (hereinafter 'the Government Regulation'), which the predecessor of the defendant in VIII and XI has complied with.
- [692] Following the implementation of the project entitled "Energy modernisation of the building of the TOPHÁZ Special Home in Göd", the predecessor of defendant VIII, i.e. defendant zV, carried out an on-site inspection on 13 June 2016 at the property at 2, Munkácsy M. u. 2132 Göd, and the report of the inspection was submitted to the court.
- [693] Defendant V was only entitled to check the proper quality of the project, which included the following works: thermal insulation of the façade, thermal insulation of the end slab, thermal and water insulation of the flat roof, replacement of the façade windows. According to the on-site inspection report, defendant V fully supervised the execution of those works and complied with its legal obligations.
- [694] Given that Defendant V entered into a legal relationship with Defendant II only in the context of the Environment and Energy Operational Programme, the obligations of Defendant VIII and its predecessor are governed by the provisions of the Government Decree, which Defendant VIII and its predecessor have fully complied with.
- [695] The action for a declaration against Defendant VIII IX and Defendant V is unfounded, given that the predecessor of Defendant VIII is responsible for verifying compliance with the eligibility criteria set out in the call for proposals for the KEOP-2015- 5.7.0 call for proposals.
- [696] The application against defendant No VIII in the alternative claim, in which the applicant sought only an injunction against defendant No VIII from future infringing conduct, since its predecessor in title had not ceased to exist, was also unfounded in view of the fact that defendant No VIII was not currently engaging in infringing conduct.
- [697] The compliance with the horizontal policy activities (environmental sustainability, equal opportunities) of the KEOP-2015-5.7.0 Call for Proposals and its Guidelines for Proposals (environmental sustainability, equal opportunities) was fully taken into account by Respondent No.V (on-site visit report, point 8), and the application of Respondent No.II also complied with these criteria. In the comment boxes under point 8, it is described in detail that the second defendant has complied with the deficiencies. In the light of the above, the applicant's claim for a declaration of infringement against the defendant in the first and second actions is unfounded.
- [698] As a result of the amendment introduced by Act CXXVII of 2019 amending certain Acts in connection with the creation of single-instance district office procedures (hereinafter: Efjtv.), the limited precedent system has appeared in Hungarian substantive law as a means of ensuring legal unity. According to this system, courts are obliged to follow the interpretation of the Curia, but it is also possible to deviate from the published decision of the Curia if this is necessary in order to comply with the circumstances of the case or the Fundamental Law. Any deviation - or the rejection of a party's motion to deviate from the published decision of the Curia - must be separately reasoned by the presiding judge (chamber). In the event of a dispute as to whether the derogation is justified, the parties may have recourse to ordinary and extraordinary legal remedies. A new remedy is the appeal to the court of final instance (Articles 41/A-41/D of the Code of Civil Procedure), which is an extraordinary, post-judgment, sui generis procedure aimed at the unity of the law.
{Court of Appeal Jpe.I.60.011/2021/3. no. [20] paragraph}.
- [699] The Bszi. Article 32 (1) (b) (in force: 1 April 2020) and Pp. § 346 (5)

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also stipulates that the "published decision of the Curia" means the decision published in the Collection of Judicial Decisions, which is the subject of the decision of the Court of Justice of the Republic of Cyprus. (1) of Section 41/B of the Judicial Decisions Act and published in the Collection of Judicial Decisions after 1 January 2012.

- [700] In the present action, the applicant brought an action for the application of the civil-law protection of personality against the defendants, the administrative bodies in Orders II, III, IV, V, VII, VIII and IX, which, at the time the application was lodged, had the power to perform the task which was the subject of the action and had become successors in title to that task.
- [701] The applicant claims that the above defendants violated the right to equal treatment, human dignity and personal freedom of the disabled persons accommodated in the former Tophaus by failing to comply with their duty to monitor and to take the necessary legal consequences in the Tophaus and by maintaining the harassment and direct discrimination as described in the first and second complaints against an unspecified number of disabled persons accommodated in the Tophaus and the Gondviselés Háza, in breach of the Ebkty, and the Convention on the Rights of Persons with Disabilities, and that there was an imminent risk of such a situation under Article 20(1)(c) of the Disability Rights Act, the Care Home continues to maintain such a situation and there is an imminent risk of such a situation.
- [702] Defendants II, III, IV and VII relied on the judgment of the Curia in part no. Pfv.IV.21.186/2022/10, published in the Curia's judgment no. 2023.5.131, which the court could not consider to be authoritative in all respects when making the present decision, since the claim of the plaintiff in the present action was not identical to the claim brought in that action and the facts were also substantially different.
- [703] In the above decision, the Curia ruled that:
- [704] According to Article 2:42 (1) of the Civil Code, everyone has the right to freely exercise his personality, in particular his right to respect for private and family life, his home, his right to communicate with others by whatever means and whatever means, and his right to respect for his reputation, within the limits of the law and the rights of others, and to be free from any obstacles to this. According to paragraph 2, everyone has the duty to respect human dignity and the rights of the person deriving therefrom. Personal rights are protected by this law.
- [705] [62] As a result of this regulation, the Civil Code - like the old Civil Code - is now. Section 75 (1) of the Civil Code - protects the rights of personality in general and obliges everyone to refrain from infringing them.
- [706] [63] The right of personality is a general legal relationship with an absolute structure, its content binding on everyone. From the point of view of the protection of rights, the absolute legal relationship is characterised by the fact that it is a legal relationship with negative content: only the person of the rightholder is given, against whom all others are obliged to abstain. From a substantive law perspective, this means the protection of the legitimate interest against unlawful interference by others. Such a right is not opposed by an obligated person, but everyone must avoid interfering with the absolute subjective right, the absolute character thus being the aspect of the right to be enforced against everyone. Legal relationships with an absolute structure are usually transformed into a relationship with a relative structure by some obligatory fact. Such a fact may be, for example, a contract, a tort, a violation of a personal, property or other right, a unilateral declaration [Civil Code, Art. 6:2 (1)]. In the law of personality, the relativisation of a legal relationship with an absolute structure is created by the act of violation of a personal right as a specific obligatory event, giving rise to a concrete bilateral obligation between always precisely defined persons. The violation of the right to personality thus creates a legal relationship with a relative structure between the infringer and the rightholder, which is a civil claim,

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may be the basis for a claim for the protection of personality.

[707] [64] The exercise of the subjective rights governing the realisation, assertion and protection of personality is the basis of personality. Legal protection is achieved by influencing human conduct. Therefore, any legal protection requires that the harm is caused by someone's conduct, that someone's conduct unlawfully infringes or endangers the exercise of the subjective right to personality. The objective link between the legal injury and the conduct of the infringer must therefore be proved, and the enforcement of the right is conditional on the person designated as the defendant having intruded into the personal interests of the person protected by the right [Károly Törő: Personality Protection in Civil Law, Közgazdasági és Jogi Könyvkiadó, Budapest, 1979, pp. 41-46, 89-90, 95-96].

[708] [65] **T h e** assertion of a claim for the protection of personality is only possible in a legal relationship with a relative structure, in the case of a relationship between the infringer and the injured party, because on the one hand, the identity of the infringer can be determined, and on the other hand, the conduct in the relationship between the specific persons may be capable of directly influencing the assertion of personality. It is therefore the conduct of the person liable in this relationship which gives rise to the personality relationship which may give rise to the infringement of the personality rights of the person entitled. As explained above, an infringement of personality rights means an intrusion into the personality interests of the rightholder by the conduct of the other party. Consequently, the right to personality is infringed by conduct which directly attacks personality and unlawfully invades the private autonomy of the individual, which implies a direct link between the infringer and the person who suffers harm. It is this relationship, in which the unlawful intrusion into the sphere of personality interests takes place, which creates the legal basis for the assertion of personality rights in a legal relationship with a relative structure.

[709] [66] Human rights, civil or constitutional rights (rights guaranteed by the Constitution) and personality rights are not entirely overlapping concepts.

[710] [67] Human rights as used in public international law is a broader concept than the right to personality, encompassing the protection of rights related to the personality of a person, which derive from his or her humanity, on the one hand, and rights related to the place of a person in society (political, civil, economic, social and cultural rights), on the other.

[711] "[I]t follows that neither political rights nor economic, social or cultural rights fall within this category, since these rights are not inherent in the personality of the individual, but are the consequence of his role and place in society. In the case of these latter rights, it is the State that is primarily responsible and, as the supreme sovereign, must guarantee the exercise of political freedoms and economic, social and cultural rights. Civil law does not deal with the public law relationship between the State and the legal entities, but with the relationship between the private law entities that are subordinate to it. The scope of individual rights cannot therefore include rights which require action only on the part of the State, whether in its legislative or executive role. (...) The civil rights or fundamental rights used in constitutional law are listed under the heading "Liberty and Responsibility" in the Fundamental Law and, although they include a number of individual rights, they can be understood as a limitation vis-à-vis the State. By contrast, personality rights are not listed as rights guaranteed by the state in the Civil Code.

Book II of the Civil Code, but as an absolute obligation for all legal entities to acknowledge, tolerate and refrain from infringing them" (The Great Commentary on Act V of 2013 on the Civil Code and Related Legislation, edited by András Osztovits, Opten Informatikai Kft., Budapest, 2014, Volume I, pp. 250-251).

[712] The Curia then ruled that :

[713] [70] According to Article XIX (1) of the Fundamental Law, Hungary shall endeavour to.

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provide social security for all its citizens. In the event of maternity, sickness, disability, invalidity, widowhood, orphanhood and unemployment through no fault of their own, all Hungarian citizens are entitled to statutory benefits. Paragraph (2) provides that Hungary shall provide social security for the persons referred to in paragraph (1) and for other persons in need through a system of social institutions and measures.

[714] [71] The Constitutional Court held in AB 3217/2014 (IX. 22.) that the "the Fundamental Law does not contain a constitutional subjective right to social security. Article XIX (1) of the Fundamental Law - relevant in this respect - (...) clearly declares that in Hungary the guarantee of social security is not a subjective fundamental right, but only a state objective (...). This merely requires the state to maintain and operate the social security system, without, however, creating a right for anyone under the Fundamental Law as to the specific form and extent of any benefit. This is confirmed by the statement in the second sentence that even in certain special cases (specifically maternity, sickness, disability, widowhood, orphanhood and *involuntary* unemployment) citizens are entitled to benefits only to the extent "determined by law"; that is, the specific form and extent of the benefits are freely determined by the legislature' [24]. In the decisions of the Constitutional Court (AB) 1/2018 (6/4/2018) and AB 2/2018 (6/4/2018), the Constitutional Court stressed that "although Article XIX is typically about state objectives and not about fundamental rights, this article of the Fundamental Law provides a constitutional background for the legislation on the listed life situations. The details of the statutory conditions or the conditions of entitlement as specific detailed rules do not follow from the Fundamental Law, the background of the Fundamental Law only means that the abstract entitlement follows from the Fundamental Law itself {1/2018.) AB Decision, Explanatory Memorandum [17]}, and "[e]ven though the Fundamental Law clearly provides that Hungarian citizens are entitled to state assistance under the law in certain situations, the detailed rules of this state assistance are not laid down in the Fundamental Law but in the laws in force." {Decision 2/2018 (IV.6.) AB, Reason [13]}.

[715] [72]A characteristic of constitutional rights that are not fundamental rights is that "they do not give rise to a direct subjective right under the Constitution", "[t]he constitutional designation of rights creates a legislative obligation to create rules by which the rights can be enforced. Thus, the subjective right does not derive from the constitution, but one level lower, from the law that provides for the "implementation" of the constitution" (Constitutional Law - Fundamental Rights, edited by Balázs Schanda, Zsolt Balogh, PPKE JÁK, Budapest, 2011, p. 28).

[716] [73] It follows from all the above that, according to the judgment of the Curia, the applicants' subjective entitlement to social benefits and the infringement of their individual rights based on it cannot be inferred from the Fundamental Law.

[717] It also stated that individual social entitlements cannot be considered as claims under the law of personality. A claim for protection of personality cannot be based on the constitutional background alone, on certain provisions of the Social Act which essentially regulate the possibilities, institutional framework and procedural arrangements for assistance to be provided by the state in the listed life situations. Certain social benefits may not be enforced in the context of an action under the law of personality, because the provision of such benefits requires action only on the part of the State, which is carried out in relations under public law. Therefore, social benefits cannot be included in the scope of personality rights enforceable in civil law relationships. Under Article 1:1 of the Civil Code, the Civil Code regulates the fundamental property and personal relations of persons in accordance with the principles of subsidiarity and equality. The Civil Code. § 3:405 (1) of the Civil Code also subjects the state to the personal scope of the law only in its civil legal relations. The provision of social security benefits is not a civil law relationship and does not create a legal relationship between the State or its executive

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a legal relationship based on co-determination and equality under civil law between its organs and the entities subject to public law.

- [718] In summary, the Curia stressed that the case did not involve a determination of whether the applicants were entitled to social assistance in the form of subsidised housing, as this was evident from the facts of the case. On the basis of the applications for review, the question to be examined was whether there was a civil-law relationship between the applicants and the defendants which gave rise to the asserted claim for protection of personality. In doing so, the Curia, relying on legal theory and literature, and taking into account the legal principles set out in the decisions of the Constitutional Court, held that: the right to social security benefits is not a subjective right guaranteed by the Fundamental Law, but a constitutional right which entails a statutory obligation on the part of the State to regulate and which the State grants in the light of its economic capacity at any given time; the conduct of the defendants as executive organs of the State, which is the subject of the action, is not protected by the right to protection of personality; the failure of the defendants, who exercise public authority, to perform their public duties or to carry out their general administrative activities, as alleged by the plaintiffs, does not give rise to a relationship of personality in the absence of a direct relationship between the parties; therefore, the condition for the protection of personality is not satisfied. Consequently, the court seised of the civil action, acting under civil law, has no jurisdiction, in the absence of a statutory power, to order the defendants to take measures in the field of public law.
- [719] [84] In view of the above, the Curia held that in the case at hand, the protection of personality is not a suitable legal instrument to achieve the applicants' objective, which is to be supported to a large extent by human beings, of receiving social assistance in the form of their choice, and therefore the action has no legal basis."
- [720] From all of the above, it can be concluded for the present court that the plaintiff in the present action brought an action in relation to a specific violation of the rights of the persons concerned, which was not contested by the defendants and was also established by the Ombudsman.
- [721] Contrary to the facts in the judgment of the Curia, the aggrieved parties in the present action had a direct relationship of co-assignment with the former defendant in the first instance, the now defunct Tophaus.
- [722] Defendant II was the maintainer, Defendant III was the licensor, and Defendant IV was the sectoral manager of the former Tophaus.
- [723] The Court refers back to the legislation correctly invoked in the applicant's application. The defendants themselves did not dispute their status as such.
- [724] In other words, the court considers that the decision of the Curia does not affect the outcome of the present case because of the difference in the facts.
- [725] According to Article 75 (1) of Act IV of 1959 on the Civil Code (Act IV of 1959 on the Civil Code) :Everyone shall respect the rights of the person. These rights are protected by law.
- [726] According to Article 76: Violation of the rights of the person means, in particular, violation of the requirement of equal treatment, violation of freedom of conscience and unlawful restriction of personal freedom, violation of physical integrity, health, honour and human dignity.
- [727] § 84 (1) A person whose personal rights have been infringed may, depending on the circumstances of the case, bring the following civil claims:
- [728] a) demand a judicial declaration that the infringement has occurred;
- [729] b) demand that the infringement cease and prohibit the infringer from further infringements;

- [730] (c) require the infringer to provide satisfaction by declaration or other appropriate means and, if necessary, to provide publicity for or at the expense of the infringer;
- [731] d) may demand the cessation of the injurious situation, the restoration of the situation prior to the infringement on the part or at the expense of the infringer, and the destruction of the infringing object or its removal from the status of infringement;
- [732] e) claim damages in accordance with the rules of civil liability.
- [733] Article 8 (1) of the Civil Code (Civil Code) The provisions of the Civil Code on sanctions for the violation of personality rights shall apply to violations committed after its entry into force.
- [734] (2) Civil law claims based on rights relating to persons whose rights were infringed before the entry into force of the Civil Code shall be governed by the provisions in force at the time of the infringement. The provisions of the law in force prior to the entry into force of the Civil Code shall apply to continuing infringing conduct, including omissions, which began before the entry into force of the Civil Code, even if the infringing conduct ceases after the entry into force of the Civil Code.
- [735] Act V of 2013 on the Civil Code (Civil Code) contains the following provisions:
- [736] § 2:42 [General protection of personal rights]
- [737] (1) * Everyone has the right to freely exercise, within the limits of the law and of the rights of others, his personality, in particular his right to respect for private and family life, his home, his relations with others by whatever means or media, and his right to respect for his reputation, and to be free from all obstacles to this.
- [738] (2) Everyone shall respect human dignity and the individual rights deriving therefrom. Personal rights are protected by this Act.
- [739] (3) Conduct to which the data subject has consented does not violate the right to privacy. [740] § 2:43 [Personality rights by name]
- [741] Violation of personality rights means in particular
- [742] a) violation of life, physical integrity and health;
- [743] b) invasion of personal liberty, privacy or private home; [744] c) discrimination against a person;
- [745] d) damage to honour and reputation;
- [746] e) violation of the right to privacy and the protection of personal data; [747] f) violation of the right to bear one's name;
- [748] g) infringement of the right to images and sound recordings.
- [749] According to Act CXXV of 2003 on equal treatment and the promotion of equal opportunities (Act on Equal Treatment and the Promotion of Equal Opportunities):
- [750] § 1 Based on the requirement of equal treatment, natural persons, groups of such persons, legal persons and organisations without legal personality residing in the territory of Hungary shall be treated with equal respect and care, and with equal consideration of individual aspects, in accordance with the provisions of this Act.
- [751] § 2 The provisions on the requirement of equal treatment laid down in separate legislation shall be applied in accordance with the provisions of this Act.
- [752] § 4 The requirement of equal treatment
- [753] a) the Hungarian State,
- [754] b) * local and national self-governments and their bodies,
- [755] c) organisations exercising official authority,
- [756] d) * the Hungarian Defence Forces and law enforcement agencies,
- [757] e) * a public foundations, public bodies, and employees and employers

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- representative organisations,
- [758] f) organisations providing public services,
- [759] g) * public education institutions, vocational training institutions and higher education institutions (hereinafter together referred to as "educational institutions"),
- [760] h) persons and institutions providing social, child protection and child welfare services,
- [761] i) museums, libraries, public cultural institutions, [762] j) voluntary mutual insurance funds, private pension funds, [763] k) health care providers,
- [764] l) the parties, and
- [765] (m) budgetary bodies not falling under points (a) to (l)
- [766] in the course of their employment, legal relations, proceedings and actions (hereinafter collectively referred to as the "Relationship").
- [767] Article 7 (1) Direct discrimination, indirect discrimination, harassment, unlawful segregation, retaliation and orders to do so shall constitute a violation of the requirement of equal treatment, in particular as defined in Chapter III.
- [768] (2) * Except as otherwise provided by this Act, any conduct, measure, condition, omission, instruction or practice (hereinafter together referred to as "provision") shall not be contrary to the requirement of equal treatment,
- [769] (a) which, in an unavoidable case, restricts a fundamental right of the prejudiced party in order to give effect to another fundamental right, provided that the restriction is suitable and proportionate for achieving the aim pursued,
- [770] (b) which, in cases not covered by point (a), has a reasonable and objective justification directly related to the legal relationship in question.
- [771] (3) * Paragraph (2) shall not apply in the case of direct discrimination based on a characteristic pursuant to Section 8 (b) to (e) and unlawful segregation.
- [772] Discrimination
- [773] § 8 * Direct discrimination shall be deemed to be any provision which has the effect of causing a person or group of persons or persons
- [774] a) gender,
- [775] b) race, [776] c) colour,
- [777] d) nationality,
- [778] e) * nationality, [779] f) mother tongue,
- [780] g) your disability,
- [781] h) your state of health,
- [782] i) religious or philosophical beliefs, [783] j) political or other opinions,
- [784] k) marital status,
- [785] l) maternity (pregnancy) or paternity,
- [786] m) sexual orientation,
- [787] n) gender identity,
- [788] o) age,
- [789] p) his social origin, [790] q) his financial situation,
- [791] r) the part-time or fixed-term nature of the employment or other employment relationship,

- [792] s) your membership of an interest group,
- [793] (t) other location, property or characteristic (together referred to as "property")
- [794] is, has been or would be treated less favourably than another person or group in a comparable situation.
- [795] Pursuant to Section 10 (1) of the Equal Treatment Act, harassment is defined as conduct of a sexual or other nature that is offensive to human dignity, which is related to the characteristic of the person concerned as defined in Section 8, and which has the purpose or effect of creating an intimidating, hostile, humiliating, degrading or offensive environment towards a person.
- [796] According to Section 24 (b) of the Social Security Act, "The requirement of equal treatment in the context of social security shall be enforced in particular in the application for and provision of social and child protection benefits in cash and in kind and personal care.
- [797] The law specifically addresses the prohibition of discrimination in the context of social security and health care. Equal treatment legislation in the field of social protection is based primarily on the relevant EU directives (in particular Directive 79/7/EEC and Directive 86/378/EEC). The aim of the provision is to ensure that the principle of equal treatment is applied in the application and payment of benefits under the risks covered by compulsory social security schemes, in particular sickness, maternity, family, invalidity, survivors, old age, occupational accidents and diseases, death and unemployment, and under the social assistance schemes supplementing social security.
- [798] The law provides that the requirement of equal treatment must apply to the claiming and provision of benefits financed by social security schemes, social and child protection benefits in cash and in kind, personal care, participation in disease prevention programmes and screening, preventive medical care, use of accommodation, food and other needs. The right to equal treatment includes, in particular, the right to use the same health care facilities - the place of treatment or accommodation - and to receive the same quality and effectiveness of treatment or to participate in preventive health care programmes (screening), or to receive treatment that does not entail a higher risk.
- [799] The principle of equal treatment must be applied in public and private social care systems and procedures, as well as in compulsory and voluntary social care systems and procedures.
- [800] According to Article II of the Fundamental Law: human dignity is inviolable. Everyone has the right to life and human dignity, and the life of the unborn child is protected from conception.
- [801] The right to human dignity means that there is a core of autonomy, of self-determination, outside the control of all others, whereby
- in the classical formulation - man remains the subject and cannot become an instrument or an object. It is this conception of the right to dignity that distinguishes man from legal persons, which are fully subject to regulation, with no 'untouchable' essence. Dignity is an inherent quality of human life, indivisible and indivisible, and therefore equal for all human beings. The right to equal dignity, in conjunction with the right to life, ensures that there can be no legal distinction between the value of human lives. Human dignity and life are inviolable for all human beings, regardless of their physical or mental development or condition, and regardless of how much of their human potential they have realised and why. We cannot speak of the right to life of any human being without including his or her subjective right to life and dignity. [Decision 64/1991 (XII 17) AB]

- [802] The human dignity and life of everyone who is human is inviolable, regardless of their physical and mental development or condition, and regardless of how much of their human potential they have realised and why. [Decision 56/1991 (XI.8.) AB]
- [803] Part of the right to dignity is that all people must be treated as persons of equal dignity with others, i.e. unjustified and unreasonable distinctions must not be made between individuals and groups of people. [Decision 64/1991 (XII. 17.) AB]
- [804] The Convention on the Rights of Persons with Disabilities guarantees a number of key human rights for persons with disabilities in terms of institutionalisation and treatment. Hungary was the first country to ratify the Convention, which was promulgated by Act XCII of 2007.
- [805] The Convention on the Rights of Persons with Disabilities aims to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms.
- [806] According to Article 2 of the Convention, "States Parties undertake to ensure and promote the full enjoyment of all fundamental human rights and freedoms by all persons with disabilities, without discrimination of any kind on the basis of disability."
- [807] Article 5 of the Convention specifically highlights the obligation of the State to prohibit and protect against any discrimination on the grounds of disability.
- [808] Article 7 of the Convention protects the rights of children with disabilities to enjoy the full range of human rights and fundamental freedoms on an equal basis with other children. The Convention also provides that "in all actions relating to children with disabilities, the best interests of the child shall be a primary consideration" and that States must also ensure that "children with disabilities shall, in all matters affecting them, enjoy the right to freedom of expression, to have their views taken into account on an equal basis with other children, in accordance with their age and maturity, and to receive the assistance appropriate to their disability and age in the exercise of those rights."
- [809] Article 14(1) of the Convention provides that "[a] State Party shall ensure that persons with disabilities, on an equal basis with others
- [810] a) enjoy the right to liberty and security of person;
- [811] (b) may not be deprived of their liberty unlawfully or arbitrarily, and any deprivation of liberty may be carried out in accordance with the law, and that the existence of a disability shall in no case justify deprivation of liberty."
- [812] Overall, both the Ombudsman and the defendant II, following its 2016 inspection, came to the same conclusions as the plaintiff's claim, as can be seen from the report AJBH/257/2017:
- [813] - "The rights of beneficiaries are being violated to an unacceptable extent. The institution has a feeling of neglect" (Ombudsman's report, p. 30)
- [814] - "The infection-free and hygienic environment is partially ensured." (Ombudsman's report, p. 30) [815] - "Care activities are inadequate." (Ombudsman's report p. 30)
- [816] - "(...) in the years preceding the change of manager, the institution had already developed neglectful nursing, care and housing conditions which were a serious violation of the fundamental rights of the persons served." (Ombudsman's report, p. 30)
- [817] - "the replacement of the institutional places in the Topház in Göd is an urgent and urgent task for the people concerned, because the disabled people living in such a conflictual, frustrated and empty atmosphere due to the lack of staff and material conditions

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people's chance of human life has been delayed day by day for years, as the inspection reports have revealed. " (Ombudsman's report, page 30).

- [818] - "In the institution under review, the large number of residential institutions is also noticeable "specificities" such as the extremely high number of staff (218), the lack of facilities (bathrooms, toilets, beds, mattresses) and staff (nursing staff), the lack of accessibility (equal access). All these factors force the staff of the institution to resort to forced solutions (group bathing, beds with bars, door bars) and lead to a sharp drop in the professional quality of care. All these circumstances constitute a serious violation of the fundamental rights of the persons concerned and constitute a breach of the right to human dignity of all persons equally, of the requirement of equal treatment, of the State's duty to provide special protection to persons with disabilities, and, as a whole, and in some cases in isolation, constitute a violation of the prohibition of degrading and inhuman treatment, which is not in conformity with the international obligations deriving from Article 4 of the CRPD (Ombudsman's report, p. 30).
- [819] - "the official controls of government agencies are often mainly focused on the examination of documentation and the compliance of the documentation system with the legal requirements" (Ombudsman's report, p. 31)
- [820] - "Also, the implementation and monitoring of the 62 proposals made as a result of the reservations inquiry is at what stage." (Ombudsman's report, p. 31)
- [821] As a result of the media publicity surrounding the applicant's report, the defendants were forced to comment first on the applicant's findings and then on the Ombudsman's report.
- [822] In a press release of 4 May 2017, the State Secretariat for Social Affairs and Social Inclusion of the defendant IV. stated that "The Government considers unacceptable what happened to the residents of the TOPhÁZ Special Home in Göd. The Ministry of Human Resources has launched an extraordinary investigation at the home, the results of which will be made public once the investigation is completed." (F/7) The 2nd defendant suspended the head of the 1st defendant with immediate effect, according to the communication.
- [823] On 30 May 2017, following the extraordinary investigation ordered by the defendant IV, the defendant IV prepared an action plan to remedy the deficiencies and violations identified by the defendant IV. (F/8)
- [824] The most important of these rights are: [825] - ordering an admission ban (task 1)
- [826] - reducing the number of dormitories to 4 (Task 2)
- [827] - Elimination of accident-prone infrastructure, replacement of door handles, replacement of toilet seats, shower curtains (No 8. contract No 8)
- [828] - setting cleaning schedules and dates for major clean-ups (Task 9)
- [829] - segregation of minors and adults in care, boys and girls under age (Task 10)
- [830] - employment of an adult general practitioner (task 13)
- [831] - regular dental check-ups (task 14)
- [832] - regularly brushing the teeth of cared-for persons with their own appliances (Exercise 15)
- [833] - recruit professionals with target group specific knowledge (Task 16)
- [834] - training of staff in the management of aggression and restraint measures (Task 17)
- [835] - detailed assessment to reduce behavioural and behavioural problems, designing individual development programmes (Task 17)

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- [836] - recruit a professional to manage the work of the development team (task 18)
- [837] - redesigning the professional content of the mental health and sociotherapy groups, and training the group's staff (Tasks 19-20)
- [838] - properly document development and employment plans (Task 22)
- [839] - removing restrictions on the use of non-medical aids (Task 28)
- [840] - making living rooms more stimulating and homelike, taking into account the age and needs of the people they care for (Task 29).
- [841] In the court's view, the measures ordered by defendant IV are essentially the same as those deemed necessary by the 2016 maintenance and the Ombudsman's investigation. Defendant IV.r. has reached the same conclusion as t h e present plaintiff alleged in its action, namely, that the rights of persons with disabilities were violated on a massive, severe scale and in many areas of life at the former Defendant I.r., which has since been terminated.
- [842] All the former and current residents of the institution have a protected characteristic (disability) as defined in Section 8(g) of the Act on the Protection of Persons with Disabilities. I.r., i.e. all the disadvantages were related to their disability and closely related institutionalisation.
- [843] According to Section 8 of the Equal Treatment Act, in order for direct discrimination to be established, it is sufficient to prove that the aggrieved party is treated less favourably than another person or group in a comparable situation would be treated because of a protected characteristic.
- [844] Given the fact that the defendant I.r. exclusively catered for disabled persons, it is thus conceptually precluded to identify a group that would be in a situation comparable in all respects to the persons residing with the defendant I.r. except for the protected characteristic.
- [845] All residents of the first respondent institution are disabled persons.
- [846] Care homes are places for people who are unable to care for themselves or can only do so with constant assistance. These institutions must provide at least three meals a day, mental care, a certain level of health care, housing and, if necessary, clothing and other textiles.
- [847] A home for disabled persons is a place where a disabled person can be cared for if education, training or care is available only in an institutional setting.
- [848] Therefore, anyone who is not a resident of the defendant I.r. is considered to be in a comparable situation.
- [849] On this basis, it can be concluded that Tophaus's carers were disadvantaged because of their disability and that the infringements were committed because of this disadvantage.
- [850] On the basis of the bionymment proceedings conducted, the court found that the freedom of the disabled persons cared for by the defendant I.r. was massively restricted in a prohibited, humiliating and harmful manner. The residents were forced to bathe and use the restroom in subhuman conditions and their dignity was seriously violated by the bathing procedure used by the defendant I.r. The showering of the disembodied and immobilised residents from a distance with cold water in the presence of others was undoubtedly inhuman and degrading treatment which also violated the international prohibition of torture.
- [851] The housing conditions provided by the defendant I.r. were seriously unlawful. Defendant I.r. was not barrier-free. The housing conditions were in several cases contaminated and dangerous (filth, faeces-covered fixtures, walls), and in several cases the

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The equipment was bleak, barren, not at all suitable for the stimulation of the residents, not taking into account the mental and health condition of the residents, their special needs, i.e. it did not meet the requirement of reasonable accommodation. The housing conditions were a serious affront to the human dignity of the disabled residents and in some cases endangered their physical integrity, creating a degrading and humiliating environment.

- [852] The lack of mental health care may have played a role in the situations and conflicts that led to the imposition of restraints. The provision of as many activities, experiences and physical exercise as possible for the beneficiaries plays an important role in preventing escalation of conflicts and situations that can lead to (self-)aggression.
- [853] Neither the elderly nor the minors in care had access to even level care.
- [854] The disabled persons placed with the defendant I.R. did not have access to care beyond the most basic physical needs that would be appropriate to maintain and develop their abilities. They have shown serious signs of neglect which, far from serving to develop their abilities, has led to a drastic deterioration in their physical, cognitive and emotional condition, thus seriously impeding their social inclusion and independent living.
- [855] At the defendant I.r. neither the personal nor the material conditions were given for the enforcement of the right to health care of the beneficiaries. In addition, the available evidence shows serious failings in the neglect of the residents' injuries, their morbid thinness and the lack of dental treatment and control. In view of the above
The right to health of disabled persons living with defendant I.r. was also violated.
- [856] Considering that the court held the above to be ascertainable facts, together with the fact that the above facts were not disputed by the defendants themselves, it held that the liability of the defendants II, III and IV, who were subject to the inspection, could also be established. The court was of the opinion that, had the defendants II, III and IV complied with their obligations in time, they would have
- [857] - the infringements would have been detected in time;
- [858] - would have required the defendant I.r. to immediately put an end to them, including the imposition of a moratorium on the recruitment of new beneficiaries;
- [859] - would have verified that the defendant I.r. had complied with its obligations in time;
- [860] - and, in addition to the above, if the defendant I.r. did not comply with the obligation, the defendants would have been obliged to initiate the necessary criminal, labour and administrative proceedings to apply the appropriate consequences.
- [861] The court refers in this context to the judicial practice followed in school segregation cases. Based on the established case law on the responsibility of both the maintainer and the sectoral manager in educational discrimination cases, the responsibility of both the maintainer and the sectoral manager of education in maintaining segregation between educational institutions can be established..936/2008/4, Supreme Court judgment Pfv.IV.21.568/2010/5, Curia case published in BH 2018.5.140., Curia judgment Pfv.IV.20.857/2022/10).
- [862] The Second, Third and Fourth Defendants had the statutory authority to take effective and genuinely effective measures to bring the infringements to an end. By failing to take such effective measures, they have contributed to the perpetuation of the infringing situation by their passive attitude.
- [863] The persons represented by the applicant were in a legal relationship with Tophaus. It is this relationship of care which gives rise to the liability of any further defendant (II, III and IV

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defendant), which had some power of control and management over Topház. Hence, the liability of defendants II, III and IV for breach of the requirement of equal treatment exists.

[864] The court found the infringement in the operative part of the judgment.

[865] The court found that there was insufficient evidence of access to justice in the case.

[866] The Court of First Instance departed from the wording of the claim for declaratory relief submitted by the claimant, on the ground that the court is not bound by the manner in which the declaratory relief is sought.

[867] It is clear from the provisions relating to the finding of infringement what conduct - in this case, what omission - of the defendants in Orders II, III and IV infringed the right of personality of the persons represented by the applicant.

[868] The court refers in this context to the Supreme Court's decision on press vindication procedures in PK.

Resolution 15, which is also consistently applied by the courts in personality rights litigation.

[869] The court also ruled that the action brought against defendant VI was unfounded.

[870] The court found that the Pest County Topház Unified Social Institution, defendant I, had ceased to exist during the pendency of the lawsuit without legal succession, and defendant VI continued its activities in the social institution called the House of Care Home for Disabled People.

[871] The expert opinion of the Eötvös Loránd University Bárczi Gusztáv Faculty of Special Education and Dr. Brigitta Baran, forensic psychiatrist, obtained in the lawsuit, concluded that the investigation of the Hungarian Maltese Charity House of Charity, the personal visit to the institution and the documentation examined showed that the restrictive measures applied in the institution and their documentation were lawful according to the provisions of the law 1/2000.(1/2000) of the Ministry of Social Affairs and Labour in the manner prescribed by law in the data sheet and the insert sheet pursuant to § 101/A (3) of the Decree of the Ministry of Social Affairs and Labour. Furthermore, that the neurological and mental psychiatric health care of disabled persons accommodated in the House of Care is currently provided in accordance with the rules of the profession, modern therapeutic protocols, approaches and legislation, and is documented in accordance with the practice and documentation. Child and adolescent psychiatric care and adult psychiatric care are also reassuring and continuously available with a modern approach. Specialist services, as deemed necessary by the institution's doctors and specialist nurses, are readily available. The institution employs 1 child and 1 adult doctor on a part-time basis, whose flexible office hours and unscheduled availability ensure that no resident is left unattended. A more accurate assessment of the physical status of residents (paediatric, dermatological, gynaecological, dental).

[872] However, the expert opinion states that access to and implementation of routine screening is a problem, and the domestic health care system is not sufficiently prepared/planned to provide the large number of people with special needs in the procedural area with non-discriminatory and routine access to care outside the urgent care setting. However, steps are being taken to improve this and to address screening, and the institution has contacted the Semmelweis University Dental Care Centre, which is starting to operate as part of the network for dental care for people with autism. The concrete implementation of the screening and care of residents has been hampered by the Covid epidemic.

[873] The expert opinion also pointed out that, on the basis of current experience in the institution, there was no overall indication that the physical and mental condition and needs of the disabled persons accommodated in the House of Care were not being met on the spot.

available, medical care would be inadequate and would require the immediate involvement of an external doctor. However, the problem of access to health screening would need to be addressed and the institution would need support.

- [874] As for the special needs teachers and development specialists, the complex needs assessment related to TL was carried out for all residents, and the experts were given insight into this as well. However, the needs cannot be adequately met in the absence of properly trained professionals. In the field of public education, the school district responsible for the provision of remedial education for pupils in the TL does not provide adequate human resources. In the case of adult residents, although staffing levels are in line with the legislation, the lack of qualified staff does not ensure that human resources are available to respond to needs in a relevant way and are trained in theory and practice. The MMS and the institutions it supports are making great efforts to ensure that they have the best possible staff to meet the needs that arise.
- [875] The expert opinion also pointed out that both the legal representative and the legal representative provided with information on the application of the restrictive measures. As regards the monitoring of the restrictive measures and the maximum duration and lifting of the measures, the rules of the institution contain detailed procedures in accordance with the law, which are thoroughly familiarised by the care staff in the framework of repeated training and followed in practice. There have been no complaints about the use of restrictive measures in the institution since 2017.
- [876] Taking into account the extensive proactive and preventive measures and the internal rules, regulations and compliance with the provisions of the CRPD, as well as the operating principles of the institution and the institutional culture following the change of maintenance, it can be summarised that the legal protection of the persons using the services of the House of Care is ensured. The relationship with the IJS representative for the care of the elderly, who operates within the framework of the legislation in force in the country and the budgetary resources, is intensive and is also meaningful on the part of the residents. When a need for legal assistance arises, residents who communicate well verbally receive appropriate guidance and representation appropriate to their case. In other cases, the so-called "institutional monitoring" carried out by the Ombudsman is of real help, as correspondence between the Ombudsman and the head of the institution testifies.
- [877] Equal access to legal aid, based on the quality and quantity of legal aid to be provided by the state as required by the CRPD, needs to be further developed.
- [878] Overall, the House of Caring operates in accordance with national sectoral legislation to promote and protect the human rights of all persons with disabilities, including residents with special needs. This is also reflected in the Professional Programme of the House of Care - Home for People with Disabilities (Hungarian Maltese Charity Service) approved on 27 August 2018, and the principles set out therein, as well as the organisational culture that is developing along these lines. The management of the institution strives to help the residents to live as self-sufficiently as possible, taking into account the degree of disability, which means planned personal development and assistance in making individual and community decisions based on specific needs.
- [879] Given that any culture change is a process of shaping employees' attitudes, but also the development of the independence of those who have been living here for decades is a time-consuming, step-by-step process, the management of the institution should take into account the age, condition and

the achievement of independence, at a pace and to a degree appropriate to the disability, as the goal of self-care and living arrangements.

- [880] The staff surveys that provide feedback on the attitudes and attitudes of the staff towards people with disabilities are part of the IFKT. It shows the gaps in staff knowledge of basic concepts of community inclusion at the time of the transition, the ways and channels of communication, and the support they need to work to a higher standard.
- [881] The increased need for regular case discussions and the indispensability of mentoring and supervision is clear. Staff in the institution have a strong need for professional dialogue and are open to new knowledge and training. Despite this, there was a high turnover of staff following the change of management: those who could not or did not want to go along with the new management and the change of approach and professional direction they had brought about, as set out in the CRPD, left their previous jobs.
- [882] It is clear from the above that not only the service users and the management, but also the staff community have come a long way - attitudinally and culturally - over the past 3 years, and this multifaceted development is not yet over. From a paternalistic institutional culture of decades ago, they are striving to move to a world of human rights for persons with disabilities, enshrined in the human rights catalogue, where human dignity, equality before the law and the autonomy of adults are fully respected, and where they can receive the support and assistance they need to achieve this.
- [883] On the basis of the expert opinion, the court finds that the VI. r. defendant VI - ensures the lawful operation of the institution, neither its methods nor its staff are harassing, nor does it maintain degrading and humiliating living conditions, nor does it discriminate against residents, nor does it restrict the personal freedom of residents, the restrictive measures applied on a case-by-case basis are in accordance with the law and the principle of proportionality, it provides sanitary facilities for residents, it continuously improves the living environment, it continuously improves supported housing facilities, and it is about to start a complete reconstruction of the institution, the development programme has a strong emphasis on the habilitation and rehabilitation of residents and the possible use of early development and care methodologies and tools, regardless of age, and, despite the fact that the institution no longer has any residents in the early development and care category (0-2 years), it ensures their right to education by providing them with such support, ensuring access to the designated educational establishment for all residents, providing an appropriate educational environment within the walls of the institution for travelling teachers, ensuring the residents' health care with a permanent medical presence and access to specialist care for all their needs, with the assistance of the public health care system.
- [884] The properties renovated by Defendant VI are not residential homes, but subsidized housing properties that provide services to each recipient according to his or her individual needs. Defendant VI has purchased family houses to provide low-income care, which it has renovated, modernised and adapted to the needs of the recipients, thus ensuring person-centred support. As the houses were purchased within the surrounding municipalities, community participation of persons with disabilities is achieved.
- [885] The professional process of eviction includes a complex needs assessment of the residents, which is the basis for an individual service plan. The defendant has fulfilled this obligation. The final deadline for the completion of the community inclusion process is 31 December 2024, which is the date of the judgment

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has not yet expired.

- [886] Based on the record of the lawsuit, including the expert opinion, the court found that it was not the responsibility of the defendant VI to provide the education necessary for the residents to fulfill their compulsory education requirements. It is the responsibility of the defendant VI to ensure the availability of educational institutions or to receive travelling teachers, whereas it is the responsibility of the parents or guardians to enrol the resident in the case of compulsory education. In addition, the defendant VI, despite the fact that the school-age children who were admitted to the institution had valid expert reports, requested that each minor be re-examined by an expert in order to ensure that he or she was admitted to an educational establishment appropriate to his or her condition and ability. The defendant VI is not responsible for the method and quality of the educational activities of the host institutions.
- [887] All the therapeutic staff employed in the defendant institution have a higher education qualification that complies with the requirements of Annex 3 to Decree No 1/2000 (I.7.) of the Ministry of Social Affairs and Labour of the Republic of Lithuania on the professional duties and conditions of operation of social institutions providing personal care, which contains the minimum qualification requirements for the position of staff employed in social institutions providing personal care.
- [888] The defendant institution is not a health institution but a social institution and therefore does not provide general and specialised health services. However, as stated in the expert opinion, it fully complies with the legal obligations relating to the permanent medical supervision of residents and makes every effort to ensure access to specialised and regular screening tests. However, as stated in the expert opinion, the screening of persons with serious mental disabilities (ophthalmology, dentistry, specialised screening for women and men) requires special conditions. In some cases, this can only be done under general anaesthesia. However, the public health care system is not equipped to deal with these special care modalities. Private health care institutions are not a target group. This leaves the defendant institution vulnerable to systemic deficiencies, both in terms of the possible lack of specialised equipment and the lack of sensitisation programmes involving nearby hospitals and specialist clinics.
- [889] In addition to this, the expert opinion clearly states that the mental and health condition of the residents is appropriate, not justified and that there is no need for immediate medical screening or intervention.
- [890] In the court's view, the expert's opinion is uncontradicted and unobjectionable: it has accurately and in sufficient depth explored the operation of the defendant institution, it has established that the operation of the defendant institution complies with the domestic legal provisions, the personal violations described in the plaintiff's claim could not be established on the basis of the investigation, therefore, in the court's view, the plaintiff could not prove the cause of action against the defendant in the proceedings. On the basis of the above, the Court dismissed the action against the defendant in Case VI.
- [891] The court emphasises that this does not affect the fact that the court agreed with what is apparent from the report AJBH/257/2017, i.e. that the Ombudsman's report found serious violations of the law in relation to the former first-tier defendant of the Pest County Topház Unified Social Institution, which was dissolved during the proceedings, which was not contested by the defendants in the present proceedings.
- [892] However, based on the expert opinion obtained later in the present action, it was found that the defendant VI had remedied the infringing situation and no prejudice to the residents could be established.
- [893] The court also stresses that the shortcomings indicated in the expert opinion are of a personal nature.

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in no way establish an infringement.

[894] On this basis, the court dismissed the entire claim against defendant VI.

[895] Given that the court is of the opinion that the action against the defendant in Form VI is unfounded and therefore there is no room for the application of the remedies, all the actions of the applicant for the application of the remedies in the present situation are unfounded.

[896] The court points out that the plaintiff's claim against defendant VII was only for the application of res judicata and was therefore also without merit.

[897] The court points out that the measures requested by the plaintiff go beyond the scope of a personal rights action and the possible means of obtaining objective legal remedies for a violation of personality rights.

[898] Defendants V, VI, VII, VIII, and XIX were successful in their entirety. The plaintiff, in view of his total or partial lack of standing, is a party to the old Civil Code. Pursuant to § 78(1) and § 81(1) of the old Civil Code, the court is obliged to pay the costs incurred by the defendants' legal representation, which the court has determined in accordance with IM Decree No. 32/2003 (VIII. 22.) on the attorney's fees in court proceedings (hereinafter IM Decree).

[899] The value of the suit for all defendants, taking into account the undetermined value of the suit, is HUF 600,000.- pursuant to Section 39 of Act XCIII of 1990 on Fees (Itv.) (1)(b).

[900] The court found that the defendants, with the exception of defendant VI, did not charge their costs, and asked for them to be assessed on a discretionary basis, and thus the court assessed them at 5% of the value of the action as defined in the IM Rules.

[901] As regards defendant VI, the court found that the attorney's fees charged were excessive and reduced them.

[902] In addition to the value of the case, the lawyer's/attorney's fees were also reduced because the plaintiff did not assert a property claim in his action.

[903] The plaintiff foundation, the defendants V, VI, VII, VIII and XIX became the successful plaintiff and the other defendants became the budgetary bodies which were appointed by the Itv. They are entitled to a full personal exemption from fees pursuant to Article 5(1)(f), and therefore the fees incurred are borne by the State.

Budapest, 27 February 2024.

Dr. Jakabosné dr. Németh Monika s.k.
council president