

Guatemala City, October 12, 2012.

RE: Application for precautionary measures in favor of the 334 people with mental disabilities interned in the Federico Mora Hospital, in Guatemala, Guatemala.

Mtro. Emilio Álvarez Icaza
Executive Secretary
Inter-American Commission of Human Rights
Washington D.C.

Disability Rights International and the Human Rights Office of the Arch-Bishop of Guatemala (henceforth “the petitioners”) submit the following to the Honorable Inter-American Commission of Human Rights (henceforth “the Commission,” “Inter-American Commission,” or “IACHR”), requesting precautionary measures, in accordance with article 25 of the IACHR rules of procedure, on behalf all 334 people with disabilities detained at the National Mental Health Hospital in Guatemala City (hereafter “Federico Mora” hospital).

I. Summary and Overview

Disability Rights International (DRI) has documented human rights in many psychiatric hospitals in Latin America where people are left in a state of neglect and are subject to inhuman and degrading conditions (see reports on Argentina, Mexico, Peru, and Uruguay posted at www.disabilityrightsintl.org). DRI successfully petitioned this Commission for precautionary measures to protect the lives and integrity of people detained in the psychiatric facility in Paraguay. Based on our observations from visiting the Federico Mora Hospital and from collecting dozens of testimonies from current and former staff, patients, and other sources in Guatemala, we have come to the conclusion that the Federico Mora Hospital is the most dangerous facility our investigators have witnessed anywhere in the Americas.

The 334 children and adults detained at Federico Mora are subject to immediate risk of serious physical and psychological harm, including death, because: (1) they are subjected to physical and sexual abuse; (2) they are denied medical care and receive negligent or inappropriate psychiatric and medical treatment which threatens their lives, their health, and their personal integrity; (3) they are exposed to serious and contagious illnesses and infections that, because they are not treated adequately, result in the loss of their life; (4) they are at risk of contracting HIV, a problem compounded by the widespread sexual abuse in the institution; and (5) they are placed in isolation rooms and there subjected to near total social and sensory isolation, a practice that – when applied to minors and people with mental disabilities – has been recognized by the UN Special Rapporteur on Torture as inhuman and degrading treatment or torture. To date, at least seven

people have died in recent years as a result of injuries and damage caused in the isolation rooms.¹ We have not been able to obtain exact figures as to the number of deaths in the facility, but psychiatrist staff at the institution estimate that the death rate is *at least* 20 persons per year (approximately 6% of the total population).²

The danger at the facility stems from a basic lack of law and order. Authorities do not regulate or supervise conditions in the hospital, failing to provide basic life-and-death protections, let alone meaningful physical or mental health care. The hospital is located next to a prison, and numerous armed police and guards are stationed at the facility to watch over 70³ criminally committed forensic patients⁴ who are mixed in with a population of minors and adults (men and women) with a range of intellectual and psychiatric disabilities. Staff and patients report that violence is widespread at the facility, and armed guards are the worst perpetrators of abuses. The risk of sexual abuse is so high that newly admitted minors (boys as young as 15 or 16) are held in isolation cells and acute women are kept locked in their Ward, to protect them from the risk of sexual violence. The facility is located in one of the most dangerous sections of Guatemala City, Zone 18, where there is a strong presence of gangs (such as *Maras Salvatruchas*) that engage in drug, arms, and sex trafficking. Staff have identified that some members of staff and armed guards as associated with gang members or other criminal elements. **According to staff at the facility, authorities at the hospital are afraid of removing or disciplining staff members who engage in violence and abuse at the facility. Health authorities lack effective control of this facility, and thus Federico Mora is effectively operating as a prison and not a hospital.**

Based on our observations from four visits to the psychiatric facility by the petitioners,⁵ plus dozens of first-hand accounts from current and former staff, as well as patients at the hospital, we conclude that *any* person with or without a disability detained in this hospital faces immediate risk to his or her life, health and personal integrity, as well as risk of inhuman and degrading treatment

¹ Interview with the coordinator of the Hospital Human Rights Commission and with a social worker, March and August 2012, and with a former psychiatrist in March 2012 and with a psychiatrist from Ward III and IV in August 2012.

² This number includes the deaths of patients who are referred to general hospitals due to their medical condition, and die over there. Interview with psychiatrists on staff, March 2012.

³ Interview with the psychiatrist in charge of the forensic detainees, March 2012 and with a social worker from Ward V, August 2012.

⁴ Forensic patients are people sent to the hospital by judicial order from the criminal justice system. There are three main categories of forensic patients: (1) criminally committed prisoners transferred to the facility for care of their mental illness; (2) people who are being evaluated to determine whether they are mentally ill or fit to stand trial; and (3) people with mental disabilities charged with a crime found to be unfit to stand trial. Psychiatrists at Federico Mora report that many of the detainees are no longer mentally disabled and are medically discharged, but they cannot be released because of the court order.

⁵ In August 2011, DRI attended a workshop on human rights at the Federico Mora Hospital. The petitioners visited the Hospital for a second and third time in March and August 2012. Given the lack of openness demonstrated by the Hospital in August 2011, the petitioners carried out these visits without notifying the Hospital authorities. , The fourth visit was carried out on September 20, 2012, when the ODHAG got access to the Hospital because it organized a workshop for staff on the prevention of torture, in collaboration with the Office of the Human Rights Ombudsman of Guatemala and the local UNHCHR.

or torture, in violation of the respective rights enshrined in the American Convention on Human Rights (henceforth “the American Convention”, “the Convention” or “the ACHR”)

The most immediate step that the Government of Guatemala can take to protect against further abuse is to end any new placements at the facility so that people with disabilities in need of assistance and support are not further exposed to these life-threatening risks and the attendant emotional anguish that can only contribute to further disability. Urgent steps are also needed to create alternative safe places to live for the children and adults, including women, now detained in the facility. Once their basic safety and immediate medical needs are met, efforts must be made to ensure appropriate mental health treatment and support.

II. FACTS

A. Arbitrary Detention and Improper Segregation

The Federico Mora Hospital is the only public psychiatric facility for adults in Guatemala,⁶ a country of about 14 million people.⁷ The Hospital is located in Zone 18, one of the most dangerous sectors of the city, next to a prison,⁸ where gangs have great influence.⁹ There are no public community-based services or support systems in Guatemala for adults with mental disabilities.¹⁰ Given the lack of alternatives, many people with disabilities and their families have nowhere else to turn. Some patients are placed there by family members and any person in Guatemala who has a psychiatric breakdown or an intellectual disability is at risk of also being detained at this hospital. The facility is intended for adults, but children as young as fifteen are mixed in with the adult population.¹¹ People with disabilities who are non-violent are detained in

⁶ Disability Ombudsman, *Informe de Monitoreo al Hospital Nacional de Salud Mental* [Monitoring Report on the National Mental Health Hospital] (July, 2007), p.1; Report on the Visit to Guatemala by the UN Special Rapporteur on Disability, Hissa Al Thani (2004), p.6; Information provided to DRI by a former psychiatrist at the hospital in August, 2011.

⁷ Information provided to DRI staff by a former director of the Federico Mora in August 2011.

⁸ A former Federico Mora psychiatrist said to DRI in August 2011, that “it is no coincidence that the Hospital and the Preventive Center are over there; they are the people who we do not want to disturb society.”

⁹ BBC News, “Pay Up or Die” (December 6, 2009), <http://news.bbc.co.uk/2/hi/8386584.stm>. Furthermore, according to a 2011 Police report, the area in Zone 18 in which the hospital is located (Atlántida) is one of the most dangerous areas in Zone 18 itself. La Hora, “Las diez zonas más peligrosas de Guatemala” [The ten most dangerous areas in Guatemala] (November 28, 2011), <http://lahora.com.gt/index.php/nacional/guatemala/reportajes-y-entrevistas/148368-las-diez-zonas-mas-peligrosas-de-guatemala>

¹⁰ Disability Ombudsman, *Informe de Monitoreo al Hospital Nacional de Salud Mental* [Monitoring Report on the National Mental Health Hospital] (July, 2007), p.1. Federico Mora is also the only hospital in Guatemala that provides free outpatient services. This information is from interviews conducted by DRI staff in March 2012 with an outpatient psychiatrist, a former psychiatrist and members of *El Refugio* (an organization that deals with the protection of girls who were victims of sex trafficking and sexual violence) and *REDNOVI* (a Network of non-violence against women, composed by nine women’s organizations).

¹¹ In March 2012, we found two adolescents in Ward II (acute men) –according to a nurse from that Ward, one of them was kept in the isolation room so that he would not be abused— and two adolescents in

the facility, despite the fact that they could be more appropriately treated in the community.¹² Under Guatemalan law, people may be detained by an emergency court order for up to thirty days, but many people are reported to languish in the facility against medical or psychiatric recommendations because of a lack of judicial review and because they have no place else to go.¹³ These people are referred to as “the abandoned ones.” The current sub-director of the Hospital lamented the situation during a workshop to prevent torture and other human rights violations on September 20, 2012, saying: “We violate their human rights because we do not have the resources. There is no adequate manner to treat them. We do what we can, but we cannot reject court orders.” Under Guatemalan law, there is no specific requirement of independent judicial review for all cases of psychiatric commitment¹⁴ as required by international law.¹⁵ As a result of these circumstances, the majority of children and adults detained at Federico Mora are being unlawfully deprived of their liberty and security.

Authorities at the hospital report that everyone detained at the hospital is automatically placed under the legal guardianship of hospital authorities. In fact, according to Article 308 of the Civil Code of Guatemala, “the directors of the institutions [...] of social care facilities, which house minors or *disabled persons*, are their guardians and legal representatives from the moment of

Ward I (acute women). In August 2012, we found one adolescent (Jaqueline Solares) in Ward I (acute women).

¹² Interviews with Silvia Quan, the Disability Ombudsman, and an outpatient psychiatrist at the Hospital (March 2012), and with the former sub-director of the hospital (August 2011).

¹³ Periodic revision of cases by judges is extremely haphazard – and judges often disregard the medical opinion of the staff psychiatrists who recommend release. The psychiatrists and the sub-director at Federico Mora complained that judges do not respect medical or psychiatric recommendations against commitment. Once people are brought to the hospital, they are forgotten and simply maintained at the hospital with food/shelter as an “asylum” because there is no way to release them. The sub-director of Federico Mora and the Chief of Forensic Psychiatry recounted to ODHAG the case of a person who was detained against medical advice for twelve years because their file could not be found within the judicial system.

¹⁴ There exists a procedure for civilly declaring a person mentally incompetent and committing him or her if deemed appropriate by the judge who may consult medical experts. There also exist a panoply of provisions related to competency, criminal and civil, as well as provisions for “security measures” for the protection of minors and the “incapacitated,” a catch-all term for people with disabilities ranging from blindness or other physical disability to mental and intellectual disabilities. See *Penal Code of Procedure* (articles 16, 77, 78 and 92); Civil and Merchant Code of Procedure (articles 406-410, and 516-522).

Guatemala’s provisions on legal competence violate the requirements of article 12(2) of the CRPD, which protects the right of persons with disabilities to “enjoy legal capacity on an equal basis with others in all aspects of life.” Rather than simply stripping people of their right to make decisions, the CRPD article 12(3) requires that people with disabilities be given the support they need to make decisions for themselves. Procedural safeguards required for any limitation of the right to legal capacity, set forth in CRPD article 12(4), are also absent from Guatemalan law.

¹⁵ Under article 14 of the CRPD, “States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law.” At minimum, such detention requires independent judicial review. See Eric Rosenthal and Clarence Sundram, “International Human Rights in Mental Health Legislation” 21 New York Law School Journal of International and Comparative Law 469, 527 (2002)(review international law on protections from arbitrary detention).

their admission, and their position does not require discernment.”¹⁶ This leaves people with no practical legal recourse to the justice system which has placed full legal control over all a patient’s decisions – including the decision to file a complaint – in the hands of the very hospital authorities at whose hand patients may be subject to abuse.

As a country that has ratified the American Convention and the new United Nations Convention on the Rights of Persons with Disabilities (CRPD), this system of detention violates numerous rights of people with disabilities, including the right to juridical personality,¹⁷ personal liberty,¹⁸ a fair trial, and judicial protection.¹⁹ The improper segregation from society of people with disabilities at Federico Mora violates the principle of non-discrimination enshrined in Article 1 of the ACHR. Article 19 of the CRPD makes clear that all persons with disabilities, including mental disabilities, have a right to live as part of society. .²⁰

B. Lack of supervision and control and the problem of trafficking

1. Lack of control of guards and staff

As mentioned previously, Federico Mora is located next to the largest prison in Guatemala,²¹ and the judicial system transfers numerous prisoners to the hospital because a judge deems them to suffer from a mental illness (see Section I).²² By August 2012, there were 70 forensic detainees at the Hospital. The guards are, in theory, sent to the hospital to “supervise” the forensic detainees and protect the other patients.²³ These guards belong to the National Civil Police when they are in charge of patients on remand, and to the Penitentiary System Guard when they are in charge of patients that have already been convicted.²⁴ There are a very high number of armed guards in the facility; psychiatric staff report to DRI that, in reality, the armed guards are in control of the hospital and they represent a very serious and direct security risk to patients and staff.²⁵

¹⁶ Código Civil, Decreto-Ley 106, Artículo 308. Available at <http://biblio3.url.edu.gt/Libros/2011/codigo.pdf>

¹⁷ ACHR, article 3. CRPD article 12 (right to legal capacity).

¹⁸ ACHR, article 3. CRPD article 14 (liberty and security).

¹⁹ ACHR, articles 8 and 25- CRPD, article 13 (access to justice).

²⁰ CRPD article 19.

²¹ Prensa Libre, “Preventivo de zona 18 rebasa su capacidad” (Enero 14, 2012), http://www.prensalibre.com.gt/noticias/Preventivo-zona-rebasa-capacidad_0_627537268.html

²² Medical exam is not required and judges are said to decide for themselves based on their “experience” Information provided by a former psychiatrist, March 2012. In this regard, the Disability Ombudsman documented in 2007 two cases of indigenous and illiterate forensic detainees; according to the Ombudsman, their condition as indigenous and illiterate were most likely the grounds on which they were qualified as having “mental problems” Disability Ombudsman, *Monitoring Report on the National Mental Health Hospital* (July, 2007), p. 5. See also, La hora, “Overcrowding at the Hospital Federico Mora. It is not designed to fulfill its current tasks”, (December 5, 2011).

²³ Information provided to DRI in August 2011, by the Director of Sobrevivientes, a Consultant in Forensic Medicine, by the hospital’s former sub-director, and by an outpatient psychiatrist.

²⁴ Information referred to DRI by a Hospital’s former sub-director in August 2011.

²⁵ Testimony provided to DRI by a Hospital outpatient psychiatrist and by a psychiatrist from Wards III and IV in August 2012, and by a hospital outpatient psychiatrist in August 2011. See also Disability

Guatemala's Disability Ombudsman, Silvia Quan, has observed that the guards can violate the rules of the hospital at-will and essentially "the guards own the place."²⁶

Hospital staff, unlike police guards, is theoretically under the control of health authorities. Despite many instances of abuse committed by the staff against patients, Silvia Quan, the Disability Ombudsman, reports that it is difficult to fire them because they are part of a union.²⁷ In addition, according to medical staff at the hospital, some staff have ties with criminal organizations, such as the Maras Salvatruchas.²⁸ According to the former sub-director, firing a member of the staff could result in violent reprisals.²⁹

2. No control of forensic detainees

In addition to the threat created by the guards, forensic detainees themselves are not controlled by guards or by hospital authorities.³⁰ Patients face greater risk because guards and forensic detainees have direct contact with the patients³¹ because detainees and guards move freely within the hospital facilities among children and adults detained for acute or chronic care.³²

Ombudsman, *Monitoring Report of the National Mental Health Hospital* (2007), p. 9; Disability Ombudsman Office, *Recommendation EIO-GUA-106-2002/DR May 13, 2002, "Summary of Facts,"* and "Considering" Section (D).

²⁶ Interview with Silvia Quan, August 2012.

²⁷ Interview with Silvia Quan, March 2012.

²⁸ Information provided to DRI by a former sub-director in March 2012, and by an outpatient psychiatrist in August 2011.

²⁹ Interview with a former sub-director, March 2012.

³⁰ Information reported to DRI in August 2012 by a psychiatrist from Wards III and IV, in March 2012, by Silvia Quan, the Disability Ombudsperson, and in August 2011, by a Hospital outpatient psychiatrist. See also Disability Ombudsman, *Monitoring Report of the National Mental Health Hospital* (2007), p. 6; Human Rights Ombudsman, *Recommendation EIO-GUA-106-2002/DR May 13, 2002, "Diligencias Practicadas e Informes Recibidos,"* Numeral 2.

³¹ This was observed by DRI during its visit in August 2011, March 2012, and August 2012. This was also referred to us in March 2012, by current and former hospital staff. See also Disability Ombudsman Office *Recommendation EIO-GUA-106-2002/DR May 13, 2002, "Diligence Practiced and Reports Received,"* Considering Section (c); Disability Ombudsman Office, *Recommendation EIO-GUA-106-2002/DR May 13, 2002, Considering Section (c);* La Hora, "Sobrepoblación en el Hospital Federico Mora" (Overpopulation at the Federico Mora Hospital) (December 5, 2011). In this regard, according to the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the forensic detainees and the persons with mental disabilities at the Hospital should be housed separately. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Mission to Guatemala (March, 2011),* para. 14, http://reliefweb.int/sites/reliefweb.int/files/resources/Full_Report_653.pdf. See also La Hora, "Sobrepoblación en el Hospital Federico Mora. No está diseñado para cumplir a cabalidad con tareas actuales" (Overpopulation at the Federico Mora Hospital. It's not designed to adequately handle its current tasks) (December 5, 2011).

³² DRI observed this during its visits to the Hospital in August 2011 and March 2012. This information was also referred to DRI in August 2011 by two psychiatrists at the Hospital and a consultant in forensic medicine. See also ODHAG, *Informe preliminar de la visita conjunta al Hospital de Salud Mental: Federico*

Ward V is designated for male forensic detainees, but due to overcrowding, thirty forensic detainees now reside on Ward II designated for men in need of acute psychiatric care.³³ There is no ward for female forensic detainees so they are sent to Ward I for acute women.³⁴ The presence of the forensic detainees and their guards also represents a risk for hospital staff, who also report being victims of sexual harassment.³⁵

3. Trafficking

Current and former staff at Federico Mora have reported to the petitioners that there is trafficking of drugs and alcohol between the Hospital and the prison next door in which guards and forensic detainees are involved.³⁶ According to a former sub-director as well as the current Chief of Forensic Psychiatry, forensic detainees have tested positive for marijuana and alcohol consumption; he also indicated that they are obtaining alcohol and marijuana from the guards.³⁷ It has also been reported that forensic detainees and guards provide or incite patients to consume drugs and alcohol.³⁸ A former sub-director of Federico Mora and a current member of the psychiatric staff report that no measures have been taken by the Hospital authorities to investigate these issues and to stop these forms of trafficking.³⁹

According to the hospital's Human Rights Commission⁴⁰ and current and former Hospital staff, forensic detainees force women to have sex with other patients.⁴¹ Silvia Quan, the Disability

Mora realizada por la Defensoría de las Personas con Discapacidad, la Oficina del Alto Comisionado de la Organización de las Naciones Unidas para los Derechos Humanos (OACNUDH), y la ODHAG (2011), p. 4.

³³ As of August 17, 2012, there were 30 forensic detainees in Ward II. The mixing of forensic and other patients was described to DRI in March 2012 by a psychiatrist in charge of forensic detainees and a nurse from Ward II and in August 2011 by a former sub-director. See also La hora, "Sobrepoblación en el Hospital Federico Mora. No está diseñado para cumplir a cabalidad con tareas actuales" (Overpopulation at the Federico Mora Hospital. It's not designed to adequately handle its current tasks) (December 5, 2011).

³⁴ As of August 2012, there were 12 female forensic detainees in Ward I. DRI received further reports of mixing women patients in March 2012, by a nurse from Ward I (acute women), and in August 2011, by a former sub-director.

³⁵ Interviews with a former psychiatrist at the hospital, March 2012, and with an outpatient psychiatrist, August 2011. See also Disability Ombudsman Office, *Recommendation EIO-GUA-106-2002/DR May 13, 2002, "Considering."* According to this recommendation, a female staff was constantly harassed by a forensic detainee who threatened to rape her if she did not accede to his demands.

³⁶ Information referred to DRI in August 2012, by a member of the Hospital Human Rights Commission, in March 2012, by a current and former hospital staff—specifically two current psychiatrists, a member of the Hospital Human Rights Commission and a former psychiatrist—and in August 2011, by a former sub-director and an outpatient psychiatrist. See also Nuestro Diario, "Se hacen pasar por locos, reos se fugan del Federico Mora" (Junio 28, 2011).

³⁷ Information provided to DRI by a former sub-director in August, 2011.

³⁸ Interview with an outpatient psychiatrist, March 2012. See also Nuestro Diario, "Se hacen pasar por locos, reos se fugan del Federico Mora" (Junio 28, 2011).

³⁹ Interviews with a Hospital outpatient psychiatrist, March 2012, and a former sub-director, August 2011.

⁴⁰ The hospital's Human Rights Commission was established 16 years ago, it belongs to a workers' union, and is comprised of 12 members from the medical and administrative staff. As reported by members

Ombudsman, informed us that staff has complained that female patients are trafficked to the prison next door, allegedly by the guards.⁴² Despite these allegations, there has been no official investigation of trafficking. DRI has received reports that guards pay female patients to have sexual relations with them – mostly providing them with cigarettes and alcohol.⁴³ Because these women are involuntarily detained and under the total control of the guards, this activity cannot be viewed as voluntary. In a context in which physical and sexual abuse is so prevalent, sexual exploitation and prostitution of female patients, some minors, must be considered coercive and constitutes sex trafficking.⁴⁴ Allegations that women detained in the hospital are being trafficked to prisoners or others outside the facility are very serious and deserve further and immediate investigation.

C. Abuse and Forced Contraception

The petitioners have obtained reports of routine physical and sexual abuse by guards and staff against patients, especially women, from a wide variety of sources: a former sub-director, a psychiatrist working in the inpatient unit and another psychiatrist working in the out-patient service, a social worker, a nurse, and a member of the hospital's cleaning staff.⁴⁵ The Guatemalan press has reported on the problem of physical and sexual abuse at Federico Mora,⁴⁶ and women's

of this Commission, its purpose is to serve as an observer of the human rights situation of the patients in the hospital.

⁴¹ Interview with the coordinator and a member of the Hospital's Human Rights Commission, August 2012. This information was also provided to the petitioners in March 2012 by current and previous hospital staff and members of civil society organizations in Guatemala –specifically a psychiatrist in charge of the forensic detainees at the hospital, an outpatient psychiatrist, the coordinator of the human rights commission of the hospital, a nurse from Ward III (chronic women), a former psychiatrist, the director of Sobrevivientes, and two members of REDNOVI.

⁴² Interview with the Disability Ombudsperson, August 2012.

⁴³ Information provided by a psychiatrist from Ward III and IV, by a nurse from Ward III and by Silvia Quan, August 2012.

⁴⁴ The UN Trafficking Protocol reflects the international consensus of the definition of trafficking. UN General Assembly, Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime, Art. 3(a), 15 November 2000. (entered into force Dec. 25, 2003). One way to constitute sex trafficking, as defined by Article 3 of the Protocol, is a showing that individuals are "harboured" for the purpose of exploitation by means of coercion or abuse of power and vulnerability. The situation of women used for sex at Federico Mora satisfies this definition. Psychiatric detention places these individuals in a position of vulnerability whereby guards can abuse their power and exploit them for sex. Federico Mora harbors patients through an involuntary commitment process that violates their right to liberty under international law. Once they are detained, they are under the control of guards and, therefore, are unable to give meaningful consent to sex – whether or not they receive payment.

⁴⁵ Information provided to DRI in March 2012 and August 2012. See also Disability Ombudsman Office, *Recommendation EIO-GUA-106-2002/DR May 13, 2002*, Diligence Practiced and Reports Received Numeral 3.

⁴⁶ Nuestro Diario, "Se hacen pasar por locos, reos se fugan del Federico Mora" (They pretend to be crazy, prisoners take refuge at the Federico Mora) (June 28, 2011); Emisoras Unidas 89.7, "Solicitarán

rights organizations operating in Guatemala have they have knowledge of cases of sexual abuse against women at the hospital;⁴⁷ in fact, one of these organizations referred that they received a case of a women that was raped by the nurses at the hospital.⁴⁸ A member of the staff's Human Rights Commission reports that women and girls are especially at-risk of sexual abuse.⁴⁹ The Disability Ombudsman has reported that guards and forensic detainees are responsible for widespread abuse.⁵⁰ A number of patients detained in the facility reported being subject to physical and sexual abuses, as described below.

Furthermore, there is forced contraception at the hospital. Women of reproductive age are given *Depo-Provera*⁵¹ to prevent pregnancies. According to staff, this is provided with their ordinary regimen of medications, without their informed consent.⁵² Since acute men and women are separated by gender, the use of Depo-Provera suggests an effort by authorities to cope with unwanted pregnancies deriving from sexual abuse by staff by staff, or guards or other patients at the facility.

1. Sexual abuse

We have received several allegations, and it has also been documented by the Human Rights Ombudsman Office, that guards have forced women to take off their clothes and dance, and also rape them.⁵³ The sexual abuse of patients can easily take place due to the large grassy and

construcción de cárcel para reos con problemas mentales" (Calls made for the construction of a jail for prisoners with mental problems) (August 18, 2010).

⁴⁷ Information provided to DRI by the director of *Sobrevivientes*, March 2012.

⁴⁸ Interview with a member of the Women's Association in Solidarity (AMUS for its Spanish acronym), March 2012.

⁴⁹ Interview with the coordinator and a member of the Hospital's Human Rights Commission, August 2012. This information was also referred to the petitioners in March 2012 by a former Deputy Director and in August 2011 by former and current staff of the hospital and by Guatemalan women's groups.

⁵⁰ Disability Ombudsman, *Monitoring Report of the National Mental Health Hospital* (2007), p. 5.

⁵¹ Depo-Provera is a contraceptive injection for women which contains the hormone progestin and it typically suppresses ovulation. With regards to its risks, some studies suggest that this type of contraceptives may increase a woman's risk of contracting HIV. Mayo Clinic, *Depo-provera* (2011), <http://www.mayoclinic.com/health/depo-provera/MY00995>. Other reported adverse reactions to Depo-Provera are anemia, osteoporosis, cervical cancer, breast cancer, lack of return to fertility, unexpected pregnancy, increased libido, and genitourinary infections. US Food and Drugs Administration, *Approved Information for Patients, Depoprovera: Highlights of Prescribing Information* (2011), p. 8. http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/020246s035lbl.pdf [Last visit, June 5, 2012]

⁵² Information provided in March 2012 by former and current Hospital staff –specifically by a nurse from Ward III (chronic women), a social worker, two current psychiatrists and a former psychiatrist— and by Silvia Quan and a member of El Refugio.

⁵³ Information referred to DRI in August 2012 by Silvia Quan and with the coordinator and a member of the Hospital Human Rights Commission, and in March 2012 by current and previous hospital staff and members of civil society organizations in Guatemala –specifically a psychiatrist in charge of the forensic detainees at the hospital, an outpatient psychiatrist, a nurse from Ward III (chronic women) a former psychiatrist, the director of *Sobrevivientes*, and two members of REDNOVI and in August 2011 by the Vice President of the National Union of Guatemalan Women (UNAMG). In fact, the coordinator of the Hospital

wooded areas at the hospital and the lack of supervision by staff.⁵⁴ A member of the Hospital's Human Rights Commission and a social worker reported to DRI, for example, that a patient was raped in June 2011, when she was permitted to leave the Ward to take a walk.⁵⁵ As a result of experiences like this, staff report that basic freedom of movement for acute women detained in the hospital is extremely limited. Women that receive acute treatment are kept permanently locked in their wards and cannot walk around the hospital grounds.⁵⁶ Locking women in the wards, however, does not protect them from staff or guards. Nor does it protect them from forensic detainees, some of whom are allowed to wander around the facility at will. The constant risk of sexual abuse to which women in acute treatment are exposed, was recognized by the current sub-director when she stated that the Hospital staff tries to treat these women as fast as possible and send them home to avoid their being abused.⁵⁷

A former sub-director reported to DRI that in 2010, hospital authorities received allegations that at night female patients in acute treatment performing oral sex on the guards who would stand in front of the gates of Ward I (acute women).⁵⁸ Hospital authorities responded by installing a security camera; however, according to a former sub-director, the security cameras are inadequate and do not cover all the areas where the abuses take place.⁵⁹

A psychiatrist at Federico Mora reported to DRI that newly admitted patients are especially at risk of being sexually abused by guards who "take advantage of the new internees."⁶⁰ The fact that newly admitted boys and girls are placed in isolation cells "for their protection," (see description below in Section II.D) is an indication of the total lack of control against abuse that exists in the living areas of Federico Mora. In March of 2012, DRI observed a 16 year old boy locked in the isolation room of Ward II (acute men) for this reason.⁶¹

Human Rights Commission referred to us that "the Human Rights Commission at the Hospital was created in 1996 because of the rape of a patient by a guard." See also Human Rights Ombudsman Office Recommendation EIO-GUA-106-2002/DR May 13, 2002, "*Summary of Facts*" y "Diligence Practiced and Reports Received"; La Hora, "PDH censura a policías por vejámenes contra enfermos mentales" (Human Rights Ombudsman Office criticizes police for abusing mentally ill) (June 18, 2002).

⁵⁴ Information referred to the petitioners by an outpatient psychiatrist in August and March 2012. See also Disability Ombudsman Office Recommendation EIO-GUA-106-2002/DR May 13, 2002, "*Summary of Facts*". In this respect, the Disability Ombudsperson referred to the petitioners in August 2012 that the gravest type of abuses take place at night when there is fewer staff and even less supervision.

⁵⁵ Interview with the Coordinator of the Hospital Human Rights Commission and a social worker, August 2012.

⁵⁶ Information reported by the current sub-director to ODHAG, September 2012. This information was also referred to the petitioners by coordinator of the Hospital's Human Rights Commission, an outpatient psychiatrist and a nurse from Ward I (acute women), and a former psychiatrist, March 2012.

⁵⁷ Information provided to ODHAG in September, 2012.

⁵⁸ Interview with a former sub-director, March 2012. According to this psychiatrist, as a result of this, the gates of Ward I (acute women) were blocked.

⁵⁹ Interview with a former sub-director, March 2012.

⁶⁰ Testimony provided by the psychiatrist in charge of the forensic detainees, March 2012.

⁶¹ Observed by DRI during its visit to the Hospital in March 2012. See Annex XX

According to the coordinator of the hospital's Human Rights Commission and with information documented by the PDH, guards order patients to undress, masturbate, or have sexual relations with other patients in front of them.⁶² In Ward III, DRI investigators observed women and men left naked from the waist down.⁶³ According to the hospital's Human Rights Commission and current and former Hospital staff, forensic detainees are one of the main perpetrators of sexual abuse of women in the hospital, and they also force women to have sex with other patients.⁶⁴

Patients who experience abuse report that their complaints are ignored. One woman formerly detained in the hospital reported to DRI that she was sexually abused by a male nurse. "When I woke up," she said, "the nurse was taking off my clothes and touching my breasts. [...] When I told the doctors that the nurse tried to abuse me, the doctors didn't believe me."⁶⁵

Even members of staff are afraid to report abuses. A member of the Hospital's Human Rights Commission and a psychiatrist reported to DRI that, on August 8, 2012, a physician at the hospital witnessed a guard fondling a patient from Ward I through a broken window.⁶⁶ According to a Federico Mora psychiatrist, the guard then threatened to abuse the physician "in the same way" if she reported the incident. She was too frightened to lodge an official report.⁶⁷

2. Physical abuse

A member of the Human Rights Commission reported to DRI that forensic detainees, some of whom were convicted of violent crimes, strike the patients and force them to perform acts against their will.⁶⁸ DRI received numerous reports from staff psychiatrists and from the Disability Ombudsperson, further corroborated in the Guatemalan press, that guards disrespect the patients, mock them, and frequently force them to commit acts for their entertainment.⁶⁹ According to staff and patients, guards kick and hit the patients – especially women.⁷⁰ During

⁶² Interview with the coordinator of the Hospital's Human Rights Commission, March 2012. See also Human Rights Ombudsman Office, Recommendation EIO-GUA-106-2002/DR May 13, 2002, "Summary of the Facts"; Prensa Libre, "Pacientes de Hospital viven atemorizados" (Patients at the hospital live in fear) (June 6, 2010).

⁶³ DRI investigation March 2012.

⁶⁴ Interview with the coordinator and a member of the Hospital's Human Rights Commission, August 2012. This information was also provided to the petitioners in March 2012 by current and previous hospital staff and members of civil society organizations in Guatemala –specifically a psychiatrist in charge of the forensic detainees at the hospital, an outpatient psychiatrist, the coordinator of the human rights commission of the hospital, a nurse from Ward III (chronic women), a former psychiatrist, the director of Sobreviventes, and two members of REDNOVI.

⁶⁵ Testimony provided by a former patient, March 2012.

⁶⁶ Interview with member of the Hospital Human Rights Commission, August 2012.

⁶⁷ Interview with a psychiatrist from Wards III and IV, August 2012.

⁶⁸ Interview with the coordinator of the Hospital Human Rights Commission, March 2012.

⁶⁹ Information referred to DRI in August 2012, by the Disability Ombudsperson and by an outpatient psychiatrist, and in March 2012, by an outpatient psychiatrist and by a former psychiatrist. See also Prensa Libre, "Pacientes de Hospital viven atemorizados" (Patients at the hospital live in fear) (June 6, 2010).

⁷⁰ Information provided by a psychiatrist of Wards III and IV in August 2012, and by a social worker and a 16 year old former patient from Ward I (acute women), in March 2012.

DRI's March 2012 visit to the Hospital, investigators in the patio behind Ward VI (geriatrics) witnessed a group of five guards encircling and taunting a patient, ordering him to dance, jump, and run; the guards also threw him garbage and plastic bottles⁷¹

Guards also abuse forensic detainees.⁷² In fact, the Human Rights Ombudsman in its recommendations found that the guards that belong to the penitentiary system and the police were responsible for violence against forensic detainees under their protection.⁷³

Staff members of the Human Rights Commission report to DRI that physical abuse is committed by male nurses or staff on the wards who treat the patients aggressively.⁷⁴ In March 2012, a female patient reported to DRI that patients were often assaulted by ward staff.⁷⁵ In August 2012, a 16 year old girl (from Ward I), reported to DRI investigators that the nurses mistreated her.⁷⁶ We also received information regarding a recent case when a nurse hit a patient and left him with severe wounds.⁷⁷ A nurse in Ward II (for acute men), reportedly threw a patient out of his bed as a way of waking him up.⁷⁸ In December 2011, a nurse, associated with the *Maras Salvatruchas*, hit a patient causing him serious injuries.⁷⁹ In August 2012, staff at the San Juan de Dios General Hospital reported that one of the main reasons patients from the Federico Mora are referred to the San Juan de Dios General Hospital is the incidence of fractures due to physical abuse, though the exact origin of the injuries is often not known.⁸⁰ During 2010 and 2011, six patients were referred to this General Hospital due to hematomas and fractures.⁸¹

⁷¹ Observed by the petitioners in March 2012.

⁷² PDH, *Recommendation REF.EXP.ORD.GUA. 2595–2009/DE January 27, 2012, “Results of the Investigation.”*

⁷³ Disability Ombudsman Office, *Recommendation EIO-GUA-106-2002/DR May 13, 2002, “Resolutions.”* In this recommendation, the case of the forensic detainee Heriberto Romeo Álvarez Orozco stands out; a patient who had been shackled and beaten up by a guard in June 2011.

⁷⁴ Testimony given by a 16 year old former patient from Ward I (acute women) and a psychiatrist from Wards III and IV, March 2012; I and in August 2012 by a member of the Hospital Human Rights Commission.

⁷⁵ Testimony given by a former patient from Ward I (acute women), March 2012.

⁷⁶ Testimony provided by Jaqueline during DRI's visit to the Hospital, August 2012.

⁷⁷ Testimony given by the coordinator of the Hospital Human Rights Commission.

⁷⁸ Interview with a Hospital former psychiatrist, March 2012.

⁷⁹ Interview with the Coordinator of the Hospital Human Rights Commission and a social worker, August 2012.

⁸⁰ Interview with the Director of the Hospital Records at the San Juan de Dios Hospital and with a social worker from the emergency area of the same hospital, August 2012.

⁸¹ Specifically, a case of a temporoparietal epidural hematoma, a case of abdominal trauma, two cases of brain stroke (ischemic stroke), a case of a bimalleolar ankle fracture, and a case of a shoulder fracture, 2010 and 2011 Hospital Records from the San Juan de Dios Hospital; see Annex XX.

D. Dangers of detention in isolation rooms

Isolation rooms used in Federico Mora are not well lit dark and barren, and people detained have no human contact or activities to occupy them,⁸² what causes nearly total sensory and social deprivation. Patients in isolation are forced to urinate and defecate in the same place that they eat and sleep, and the stench of urine persists. The rooms are 2x2 meters in size, made of cement, and lack any furniture, except for a thinly worn mattress on the floor. The rooms are in general disrepair and metal doors, most of which were rusty with sharp edges and protrusions.⁸³ There is no overhead light and it is only possible to look out to the pavilions, in a limited manner, through a small window with bars. There are two isolation rooms in each ward –except for Ward VI (geriatrics).⁸⁴ During the two visits that the petitioners made in March and August 2012, we found a total of 6 people in isolation rooms. One was a boy of 16 years old.

At least seven people detained in these isolation rooms have died in recent years. Three people were strangled trying to escape through the bars in the isolation room's window.⁸⁵ Two people have committed suicide in the isolation cells: a man hanged himself by tying a cloth to the window bars,⁸⁶ and a woman hanged herself by tying a bed sheet to the door handle.⁸⁷ In another case, a person who had been in the isolation room for a prolonged period of time escaped after another patient had opened the door. The freed patient threw himself from some stairs at the back of the Hospital and died.⁸⁸ On June 29, 2012, a patient named Silvia Ochaeta hit her head hard in an isolation room and died.⁸⁹

Isolation rooms are commonly used at the hospital for people going through a psychiatric “crisis”⁹⁰ and are used even more frequently in the acute wards for newly admitted patients in an

⁸² Observed by the petitioners during their visit to the Hospital, March and August 2012. See also ODHAG, *Informe preliminar de la visita conjunta al Hospital de Salud Mental: Federico Mora realizada por la Defensoría de las Personas con Discapacidad, la Oficina del Alto Comisionado de la Organización de las Naciones Unidas para los Derechos Humanos (OACNUDH), y la ODHAG* (2011), p. 3.

⁸³ Observed by the petitioners during the visit in March 2012 and August 2012.

⁸⁴ Observed by DRI during its visits in March 2012 and August 2012. This was also referred to DRI by a hospital outpatient psychiatrist in August 2011. See also ODHAG, *Informe preliminar de la visita conjunta al Hospital de Salud Mental: Federico Mora realizada por la Defensoría de las Personas con Discapacidad, la Oficina del Alto Comisionado de la Organización de las Naciones Unidas para los Derechos Humanos (OACNUDH), y la ODHAG* (2011), p. 1.

⁸⁵ Information provided to DRI in August 2012, by the coordinator of the Hospital's Human Rights Commission, by a social worker, and by a psychiatrist in charge of forensic detainees at the hospital in March 2011.

⁸⁶ Interview with the Coordinator of the Hospital Human Rights Commission and a social worker, August 2012.

⁸⁷ Interview with the Coordinator of the Hospital Human Rights Commission and a social worker, August 2012

⁸⁸ Interview with the Coordinator of the Hospital Human Rights Commission and a social worker, August 2012.

⁸⁹ Interview with a member of the Hospital Human Rights Commission, August 2012.

⁹⁰ Information provided to DRI in March 2012 by hospital staff –specifically by an outpatient psychiatrist and by the sub-coordinator of the Hospital's Human Rights Commission— and Silvia Quan, the

“unbalanced state.”⁹¹ Numerous staff members at Federico Mora have reported to DRI that isolation rooms are also used as a form of punishment for misbehavior.⁹² Isolation rooms are also used by staff to “protect” patients from sexual abuse they would face if left among the general population of the hospital. In March 2012, DRI investigators observed a 16 year old boy held in isolation in Ward II (acute men). Staff informed DRI that he was put in isolation so that he would not be sexually abused given that “there is a lot of rape and sexual abuse in the hospital.”⁹³

There is no established protocol for how to use isolation rooms in the hospital.⁹⁴ DRI received conflicting information regarding the period of time that a patient is left in the isolation room,⁹⁵ which indicates that there is no established time and no time limit to keep the patients in these rooms. During our visits, DRI could observe that isolation rooms were occupied by people who were begging to get out.⁹⁶ In August 2012, one eighteen year old woman named Leslie asked DRI to help her get out of the isolation room, saying “I am scared, I suffer a lot here. I want to leave. Please!”⁹⁷

People placed in isolation lack supervision.⁹⁸ Isolation may aggravate of the emotional crisis that has led the individual to an emotional breakdown and involuntary confinement at Federico Mora

Disability Ombudsperson. See also ODHAG, *Informe preliminar de la visita conjunta al Hospital de Salud Mental: Federico Mora realizada por la Defensoría de las Personas con Discapacidad, la Oficina del Alto Comisionado de la Organización de las Naciones Unidas para los Derechos Humanos (OACNUDH), y la ODHAG* (2011), p. 1.

⁹¹ This information was reported to DRI in August 2012 by a Nurse from Ward I, and in March 2012 by the sub-coordinator of the Hospital’s Human Rights Commission and a Hospital former psychiatrist. In this regard, DRI was present when a newly admitted patient from Ward I (acute women) was placed in an isolation room; with regards to this patient a general doctor informed us that she “was unbalanced.” Interview with a general doctor, March 2012.

⁹² Information provided to DRI in August 2012, by Silvia Quan, the Disability Ombudsperson, by a psychiatrist of Wards III and IV and by a nurse from Ward II. This information was also referred to DRI in March 2012, by a Hospital outpatient psychiatrist.

⁹³ See video Annex XX “Isolation Room_Ward II (Acute Men)_March, 2012.” A nurse from Ward II (acute men) corroborated this information, March 2012.

⁹⁴ Observation made by Mauricio Gómez, a Chilean psychiatrist and an international expert on mental health, during his visit to the Hospital with DRI in March 2012.

⁹⁵ An outpatient psychiatrist and the sub-coordinator of the Hospital’s Human Rights Commission told us in March 2012, that patients stay in the isolation room for a “maximum of 24 hours,” a nurse from Ward III (chronic women) stated in March 2012, that patients stay there for “2 to 3 days,” while the sub-coordinator of the Hospital’s Human Rights Commission and a nurse from Ward II (acute men) told DRI that patients stay in this room until the administered medicine takes effect or the patient has calmed down.

⁹⁶ In March 2012, DRI approached an isolation room in Ward VI (chronic men) that was occupied by a patient who had been placed there and who expressed to DRI that he wanted to get out. Observed by DRI during its visit to the Hospital in March 2012.

⁹⁷ Testimony provided to DRI by a patient from Ward I (acute women). August, 2012.

⁹⁸ Interview with a hospital psychiatrist in charge of forensic detainees, March 2012. See also ODHAG, *Informe preliminar de la visita conjunta al Hospital de Salud Mental: Federico Mora realizada por la Defensoría de las Personas con Discapacidad, la Oficina del Alto Comisionado de la Organización de las Naciones Unidas para los Derechos Humanos (OACNUDH), y la ODHAG* (2011), p. 3.

Hospital.⁹⁹ The isolation rooms thus expose minors and adults to situations of severe emotional anguish and can contribute to their further emotional breakdown.¹⁰⁰

The Inter-American Court has held that “prolonged isolation and deprivation of communication are in themselves cruel and inhuman treatment, harmful to the psychological and moral integrity of the person and a violation of the right of any detainee to respect for his inherent dignity as a human being.”¹⁰¹ Given these dangers, the United Nations Special Rapporteur on Torture, Juan Méndez, has concluded that for minors and for people with mental disabilities, solitary confinement, of *any duration* constitutes inhuman and degrading treatment.¹⁰² Where conditions of solitary confinement “are so poor and the regime so strict that they lead to severe mental and physical pain or suffering” conditions may rise to the level of torture.¹⁰³ The Court has also declared that isolation rooms are not to be used as disciplinary measures,¹⁰⁴ and that conditions of detention must conform to international standards,¹⁰⁵ otherwise the detention in isolation would constitute a violation of the right to personal integrity.¹⁰⁶

The use of isolation rooms on people with mental disabilities at the Federico Mora Hospital constitutes a form of *per se* inhuman and degrading treatment. In some cases, conditions may cause such severe mental and physical pain and suffering that they rise to the level of torture. Given the large number of people who have died in isolation, the isolation of any person at Federico Mora is a direct threat to their right to life. The fact that people are placed in detention as a form of “safety” to protect them from sexual abuse underscores the broader dangers to which all patients are subject – and the inherent risks of any psychiatric detention at Federico Mora.

⁹⁹ Prolonged involuntary confinement and sensory deprivation –the total or partial restriction of stimuli from one or more of the senses—may exacerbate psychiatric symptoms or cause severe psychiatric harm, including deep agitation, extreme anxiety, panic attacks, depression, disorganized thoughts and antisocial personality disorder. Stuart Grassian, M.D., *Psychiatric Effects of Solitary Confinement*, available at:

http://www.prisoncommission.org/statements/grassian_stuart_long.pdf, p. 13. Cf., Stuart Grassian, Nancy Friedman, “Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement”, en *International Journal of Law and Psychiatry*, 8, 49-65 (1986); Wanda K. Mohr, et al., “Adverse Effects Associated with Physical Restraint”, in *Canadian Journal of Psychiatry*, vol. 48, Nº 5 (2003). For a reference on the guidelines in the use of seclusion and restraints, see, OMS, *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, at vi, WHO/MNH/MND/95.4 (1996) pp. 26-27.

¹⁰⁰ On this point, an outpatient psychiatrist, the coordinator of the Hospital’s Human Rights Commission, and a social worker, coincided (August 2012).

¹⁰¹ *Velázquez-Rodríguez v. Honduras*, Inter-American Court of Human Rights, Series C. No. 4, para. 156 (1988).

¹⁰² Special Rapporteur on Torture and Cruel, Inhuman or Degrading Treatment or Punishment, Report transmitted by note of the Secretary-General, paras. 77-78, U.N. Doc. A/66/268 (Aug. 5, 2011) (by Juan Méndez).

¹⁰³ *Id.*, para 74.

¹⁰⁴ Inter-American Court, *Case of “La unidad de internación socioeducativa,”* provisional measures regarding Brazil. Resolution of the court. April 26, 2012. Considering 22.

¹⁰⁵ Inter-American Court, *Case of “internado de Monagas “La Pica,”* provisional measures regarding Venezuela. February 9, 2006. Considering 19 and Resolution 2.

¹⁰⁶ Inter-American Court, *Lori Brenson Mejía v. Peru*, November 25, 2004. Para. 102.

E. Inadequate and dangerous medical treatment

Medical and psychiatric care is so inadequate and inappropriate as to cause life-threatening dangers for patients. A nurse working at the hospital observed that, as a result of inadequate treatment provided to patients, she observes that their mental and physical health “seriously deteriorates the longer they stay at the hospital”.¹⁰⁷ A former psychiatrist informed DRI that poor medical care at the hospital creates “a threat to the patients’ lives, and that this improper medical treatment is the major cause of deaths at Federico Mora Hospital.”¹⁰⁸

Dr. Mauricio Gómez, an independent psychiatrist from Chile who joined DRI’s investigations, concluded that, “the standard of medical treatment at the Hospital is very low, so there is a high risk that a patient’s condition becomes severe and gets worse.”¹⁰⁹ Two psychiatrists and a member of the Hospital’s Human Rights Commission report that approximately twenty patients die every year at the hospital.¹¹⁰ When DRI investigators visited in March 2012, staff reported that at least two people had died already that year from infections.¹¹¹

1. The hospital staff is insufficient and poorly qualified

There is an overall shortage of professional and direct-care staff,¹¹² making it impossible for patients to receive the individualized care they need.¹¹³ There are general doctors working as psychiatrists and medical students in their last year providing medical attention to the patients.¹¹⁴

¹⁰⁷ Information provided to DRI in March 2012 by a nurse from Ward VI (geriatrics).

¹⁰⁸ Interview with a former psychiatrist from the hospital, March 2012.

¹⁰⁹ Medical Observation by mental health expert and psychiatrist, Mauricio Gómez, August 2012.

¹¹⁰ Estimations provided to DRI in March 2012 by a Hospital outpatient psychiatrist, by a former psychiatrist, and by the coordinator of Hospital’s Human Rights Commission, March 2012.

¹¹¹ Testimony provided to DRI by staff from Ward VI (geriatrics), March 2012.

¹¹² See Annex XX.

¹¹³ Information provided to DRI in August 2012, by the coordinator of the hospital’s Human Rights Commission and a social worker, and in March 2012 by the Hospital’s psychiatrist in charge of forensic detainees, as well as by a former psychiatrist and by Silvia Quan, the Disability Ombudsperson, and in August 2011, also by Silvia Quan, by the former sub-director of the Federico Mora Hospital, and by the director of *Sobrevivientes*. See also ODHAG, *Informe preliminar de la visita conjunta al Hospital de Salud Mental: Federico Mora realizada por la Defensoría de las Personas con Discapacidad, la Oficina del Alto Comisionado de la Organización de las Naciones Unidas para los Derechos Humanos (OACNUDH), y la ODHAG* (2011) p. 8; Human Rights Ombudsman Office, *Recommendation REF.EXP.ORD.GUA.1441-2009/DESC July 19 2010*, “Results of the investigation”; The International Disability Rights Monitor, *Regional Report on the Americas* (2004), p. 220; Human Rights Ombudsman Office, *Recommendation EIO-GUA-106-2002/DR May 13, 2002*, “Considering”. Prensa Libre, “Pacientes de Hospital viven atemorizados” (Patients at the Hospital Live in Fear) (June 6, 2010).

¹¹⁴ Information referred to DRI by a Hospital former psychiatrist, March 2012. See also Human Rights Ombudsman Office, *Recommendation REF.EXP.ORD.GUA.1441-2009/DESC July 19, 2010*, “Resolutions.”

The UN Special Rapporteur on Disability, who visited in 2004, observed that “personnel and staff have no training and those that do, have not had their training upgraded in years.”¹¹⁵

2. Improper psychiatric care

During our visits in March and August 2012, DRI investigators observed non-medical staff administering psychiatric medications. Even when physicians or psychiatrists are involved in providing psychiatric care, treatment practices are so negligent as to be dangerous. Dr. Mauricio Gómez reviewed medical files and found them to be grossly inadequate. Medications are prescribed without any reference to individualized purpose or treatment plan. Without any expectation for rehabilitation and social reintegration, psychiatric treatments are limited to achieve control of disruptive behavior.¹¹⁶ Federico Mora Hospital does not have the necessary laboratory equipment to check blood levels for common medications, such as lithium.¹¹⁷ This leaves patients at risk of life-threatening blood toxicity or renal damage.¹¹⁸ In 2010, two patients that were referred to the San Juan de Dios Hospital died from lithium toxicity¹¹⁹ (a condition that can be avoided through proper monitoring of blood levels).¹²⁰ Furthermore in some cases, Dr. Gómez suspected clear cases of misdiagnosis and observed inappropriate prescription of psychiatric medications. The failure to provide individualized treatment according to a prescribed plan or to monitor side effects renders *any* use of psychiatric medications life-threatening.¹²¹

In practice, a former staff psychiatrist at Federico Mora reported that psychiatric medications are prescribed, “regardless of whether it is the medicine they need.”¹²² There are often shortages of particular psychiatric medications, so patients are switched to another medication.¹²³ A psychiatrist currently working in the outpatient unit at Federico Mora informed DRI that patients

¹¹⁵ UN Rapporteur on Disability, *Report on Guatemala Visit* (2004), p. 12. http://www.srdisability.org/regions/latin_america/guatemala/report_oct04.html

¹¹⁶ Observation made by Mauricio Gómez, a Chilean psychiatrist and an international expert on mental health issues, about the files he reviewed in Ward II (acute men) during his visit to the hospital with DRI in March 2012. The annotations that were made in the files were limited to: “the patient is agitated” or “the patient is calm.”

¹¹⁷ Interview with an outpatient psychiatrist, August 2012.

¹¹⁸ Observation made by Mauricio Gómez, a Chilean psychiatrist and international expert on mental health, August 2012). This was also corroborated by a psychiatrist at the San Juan de Dios Hospital, who stated that if a patient that is administered lithium is not administered the right dose (according to his blood levels), the patient can have a kidney complication that can lead to renal failure; an overdose of antipsychotics can also lead to organ failure (August, 2012).

¹¹⁹ San Juan de Dios Hospital Records, 2010 and 2011.

¹²⁰ Observation made by Mauricio Gómez, a Chilean psychiatrist and an international expert on mental health issues, August 2012.

¹²¹ Observation made by Mauricio Gómez, a Chilean psychiatrist and an international expert on mental health issues, March 2012.

¹²² Testimony given to DRI by a former psychiatrist, March 2012.

¹²³ These problems arising from the shortage of medications were corroborated in March 2012 by two Hospital psychiatrists, the coordinator of the Hospital’s Human Rights Commission, a nurse from Ward III (chronic women), and a former psychiatrist.

“are given what there is and not what is best for them.”¹²⁴ Using whatever psychiatric medications are available, one former psychiatrist reports that administered doses are so high as to be “inhumane.”¹²⁵

Dr. Gómez’s review of medical records confirmed that psychiatric medications are often administered in inappropriate or dangerously high dosages due to the lack of different and/or newer psychiatric medications and psychosocial interventions –such as vocational rehabilitation and support for outplacement. The only alternative for refractory symptoms –that is, symptoms that cannot be controlled with the available treatment–, is to give higher doses of the same medicines, reaching dangerous levels and causing excessive adverse effects. Medical and social work staff in the emergency ward of the general hospital report that many patients are admitted because of complications from overmedication and intoxication.¹²⁶ According to the records of patients sent from the Federico Mora Hospital in 2010 and 2011, seven patients were referred to the San Juan de Dios Hospital due to toxicity caused by medication; of these, five died.¹²⁷

Psychotropic medications must be carefully used and monitored. Even when properly administered, they can cause dangerous side effects.¹²⁸ The side effects of neuroleptics most commonly used at Federico Mora, such as Haldol and Thioradazine, include neuroleptic malignant syndrome (NMS),¹²⁹ acute dystonia, parkinsonism, cardiovascular complications (such as heart

¹²⁴ Testimony provided by an outpatient psychiatrist, March 2012.

¹²⁵ Interview with a former psychiatrist from the hospital, March 2012.

¹²⁶ Interview with a social worker from the Emergency area of the San Juan de Dios General Hospital, and a surgeon in charge of the hospital records at the San Juan de Dios General Hospital. August 2012.

¹²⁷ San Juan de Dios Hospital Records, 2010 and 2011.

¹²⁸ The most commonly used psychotropic medication is Haldol, a neuroleptic medication that can cause severe or irreversible nervous system damage or death if not properly monitored. The Federico Mora hospital also uses Thioradazine (thorazine), a very old neuroleptic with dangerous side effects. Given these life-threatening side effects, the U.S. National Library of Medicine has issued a warning regarding Thioridazine and it strongly recommends the use of other medications. See; The Mayo Clinic, *Tachycardia* (2011) <http://www.mayoclinic.com/health/tachycardia/DS00929> [Last visit, June 30, 2012]; and US Food and Drug Administration, *Haldol brand of haloperidol injection (For Immediate Release)* (2011), p.1-12, http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/015923s079lbl.pdf, [Last visit, June 30, 2012]; U.S. National Library of Medicine, *Thioridazine: Important Warning* (2011), <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682119.html> [Last visit, August 22, 2012]; World Health Organization, *Health and Substance abuse, facts and figures* (2004), http://www.searo.who.int/en/section1174/section1199/section1567/section1827_8058.htm [Last visit, June 30, 2012]

¹²⁹ The clinical manifestations of this syndrome are altered mental status, muscle rigidity, and alteration of the cardiovascular system, such as irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmias (which causes the heart to beat too fast or too slow and can be fatal if untreated). Additional signs include acute renal failure. See U.S. Food and Drugs Administration, *Haldol brand of haloperidol injection (For Immediate Release)* (2011), p. 3, http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/015923s079lbl.pdf, [Last visit, June 30, 2012]; Mayo Clinic, *Tachycardia* (2011), <http://www.mayoclinic.com/health/tachycardia/DS00929> [Last visit, August 22, 2012]; Mayo Clinic, *Heart Arrhythmias* (2011), <http://www.mayoclinic.com/health/heart-arrhythmias/DS00290> [Last visit August 22, 2012]. This

attack and sudden death),¹³⁰ and neurological and kidney damage.¹³¹ Sedatives can produce cardiorespiratory depression.¹³² When medication is not justified by a particular therapeutic need, it exposes patients to unnecessary and potentially life-threatening dangers. The practice of switching from one medication to another is itself very dangerous.¹³³

DRI investigators were able to observe the most obvious effects of over-medication throughout the institution. Many patients appeared to be heavily sedated and to have difficulties walking.¹³⁴ In Ward IV (chronic men), for example, DRI observed a man who was rigid, drooling, from the waist down he appeared to be damp from his own urine and could not stand up.¹³⁵ The Disability Ombudsperson, who visited Federico Mora independently from the petitioners, observed that “a third of the patients are sleeping the whole time, from which it can be inferred that patients are always being administered sedatives”.¹³⁶ Rather than using psychiatric medications for their

syndrome can also cause fever and muscle tissue breakdown, and requires intensive treatment. Given the complications that it can cause, it is potentially fatal. Medical consideration made by Mauricio Gómez (August, 2012).

¹³⁰ U.S. Food and Drugs Administration, *Haldol brand of haloperidol injection (For Immediate Release)* (2011), p.1, http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/015923s079lbl.pdf, [Last visit, June 30, 2012]; The Mayo Clinic, *Tachycardia* (2011), <http://www.mayoclinic.com/health/tachycardia/DS00929> [Last visit, June 30, 2012].

¹³¹ Medical consideration of Mauricio Gómez, based on the fact that Thioridazine, Lithium and Haldol are the primarily administered antipsychotics. With regards to kidney damage, a psychiatrist at the San Juan de Dios Hospital, stated that if a patient that is administered lithium is not administered the right dose (according to his blood levels), the patient can have a kidney complication that can lead to renal failure.

¹³² Overdose of sedatives such as benzodiazepines, and of Diazepam, can cause cardiorespiratory depression, which is a decrease in the effectiveness of an individual’s ventilatory function. American Society for Pain Management Nursing, *Guidelines on Monitoring for Opioid Induced Sedation and Respiratory Depression* (2011), p. 119, <http://www.aspmn.org/organization/documents/GuidelinesonMonitoringforOpioid-InducedSedationandRespiratoryDepression.pdf>; New Zealand Medicines and Medical Devices Safety Authorities, *Data Sheet: Hypnovel* (2008), p. 11, <http://medsafe.govt.nz/profs/Datasheet/h/Hypnoveltab.pdf> [Last visit, August 22, 2012]; Kumar, Arun, *Essentials of Anaesthesiology* (2006), Seventh Edition, p. 90.

¹³³ Switching medication for patients who are stable on their current antipsychotic carries some risk of destabilizing treatment for the patient in the near future as well as causing important clinical complications. Moreover, changing or stopping antipsychotics too quickly may cause an exacerbation of psychiatric symptoms as well as an interruption in the production of the key neurotransmitter acetylcholine. Weiden, Peter M.D., “Switching Antipsychotic Medications: Not Enough, Too Often, or Just Right?” in *The American Journal of Psychiatry* (2011), pp. 882-884, <http://ajp.psychiatryonline.org/article.aspx?articleid=116590#B7>; Weber, M. et al, “The risks and benefits of switching antipsychotics: a case study approach” in *Perspectives in Psychiatric Care* (2009) <http://www.ncbi.nlm.nih.gov/pubmed/19154240>. See also M. Bernardo et al “Recommendations for switching antipsychotics. A position statement of the Spanish Society of Psychiatry and the Spanish Society of Biological Psychiatry” in Elsevier Doyma, *Revista de Psiquiatría y Salud Mental* (2011) [http://www.elsevier.es/sites/default/files/elsevier/eop/S2173-5050\(11\)00008-2.pdf](http://www.elsevier.es/sites/default/files/elsevier/eop/S2173-5050(11)00008-2.pdf).

¹³⁴ Observed by DRI during its visit to the hospital in March 2012. See Annex XX.

¹³⁵ Observed by DRI during its visit to the hospital in March 2012. See Annex XX.

¹³⁶ Testimony provided by Silvia Quan, March 2012.

therapeutic purposes, the Disability Ombudsperson observed that they are often given as a means to better control patients.¹³⁷

Medication to counteract the Parkinsons-like side effects or dystonia caused by neuroleptics are absent, creating additional dangers for patients.¹³⁸ A former psychiatrist reported to DRI that she remembered a case in 2009, when a patient died because of the lack of such medications – suffocating on his swollen tongue.¹³⁹

3. Denial of medical care & lack of prevention

The lack of medical care causes life-threatening dangers at Federico Mora Hospital. Medical and nursing staff report that deaths from infectious diseases are frequent among patients.¹⁴⁰ These illnesses could be prevented or treated, but become life-threatening due to lack of attention.¹⁴¹

Federico Mora medical staff report that many deaths are caused by gastrointestinal and respiratory infections, such as pneumonia.¹⁴² Patients with infectious diseases are not isolated into protected areas, leaving other patients needlessly exposed.¹⁴³ In March 2012, there were at least 10 acute patients (out of 40) in Ward II (acute men) that had the flu.¹⁴⁴ There is an extensive problem of diarrhea at the hospital due to contaminated water,¹⁴⁵ and there have been several

¹³⁷ Testimony provided by Silvia Quan, March 2012. In this respect, a forensic psychiatrist stated that “the antipsychotics are a chemical strait jacket.” See ODHAG, *Informe preliminar de la visita conjunta al Hospital de Salud Mental: Federico Mora realizada por la Defensoría de las Personas con Discapacidad, la Oficina del Alto Comisionado de la Organización de las Naciones Unidas para los Derechos Humanos (OACNUDH), y la ODHAG* (2011), p. 3.

¹³⁸ Observation made by Mauricio Gómez, a Chilean psychiatrist and an international expert on mental health, during a visit to the Hospital with DRI in March 2012. Parkinson-like movements are a side effect of Haldol and consist of the inability to stay still or to start movement. U.S. Food and Drug Administration, *Haldol brand of haloperidol injection (For Immediate Release)* (2011), p.1, http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/015923s079lbl.pdf, [Last visit, June 30, 2012]. One of the side effects of Haldol is frequent dystonia, which consists of abnormal and prolonged muscle contractions. This can cause muscle spasms in the neck and, consequently, restriction of the throat, difficulty in swallowing or breathing, and protrusion or swelling of the tongue. U.S. Food and Drug Administration, *Haldol brand of haloperidol injection (For Immediate Release)* (2011), p.1, http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/015923s079lbl.pdf, [Last visit, June 30, 2012].

¹³⁹ Interview with a former psychiatrist from the hospital, March 2012.

¹⁴⁰ Information referred to DRI by a hospital outpatient psychiatrist and two nurses in March 2012 and August 2012.

¹⁴¹ Medical observation by mental health expert and psychiatrist Mauricio Gómez (August, 2012).

¹⁴² Information provided to DRI in March 2012, by two current psychiatrists and a former psychiatrist from the hospital. These observations were corroborated by the staff that the San Juan de Dios General Hospital by a social worker from the emergency area, and by the Coordinator of the Hospital Human Rights Commission in August 2012.

¹⁴³ Medical observation by mental health expert and psychiatrist Mauricio Gómez (August, 2012). This statement was supported by the head nurse from Ward II, August 2012.

¹⁴⁴ Information provided by a nurse from Ward II (acute men), March 2012.

¹⁴⁵ Interview with a hospital outpatient psychiatrist, March 2012 and August 2012; Testimony provided by a nurse from Ward IV (August, 2012) and by a nurse from Ward I (acute women), March 2012;

cases of patients with diarrhea who have had a hypovolemic shock¹⁴⁶ due to their severe state of dehydration.¹⁴⁷ There is also a widespread problem of syphilis at the hospital.¹⁴⁸ During DRI's visit in March 2012, staff reported that two patients had already died during the first two months of the year from infections.¹⁴⁹ During 2010 and 2011, ten patients with pneumonia and diarrhea were referred to the San Juan de Dios Hospital to receive emergency care; five of whom died.¹⁵⁰

Furthermore, it is impossible to know how many deaths result from HIV because there has been no testing for HIV since 2008.¹⁵¹ One outpatient psychiatrist reports the inpatients suffer from compromised immune systems –perhaps due to malnutrition, but in reality, it does not know its cause.¹⁵² The truth is that reason for this immune deficiency could actually be due to having HIV (for more details on the risk of contagion and lack of HIV treatment, see section II.E.5).

4. Negligence and lack of medical care

During two visits in March and August 2012, the petitioners witnessed a glaring lack of basic care and attention to patients, including:

- the failure to separate patients with infectious diseases from others, leaving others needlessly exposed to infection;¹⁵³
- numerous patients were left wearing clothing that was filthy or covered in their own urine or feces;
- a woman with serious scarring from burns on her body and face and swollen eyelids.¹⁵⁴ She was not receiving any type of protection or treatment;¹⁵⁵
- a young man lying on the floor of the hospital hallways, moving spasmodically, probably in a state of post-seizure paralysis.¹⁵⁶ Despite his serious condition, during DRI's visit, this

Interview with a Hospital outpatient psychiatrist, March 2012. In fact, this psychiatrist pointed out that patients take their medicine with water from the tank.

¹⁴⁶ Hypovolemic shock is one of the most serious, and sometimes life-threatening, complications of dehydration. It occurs when low blood volume causes a drop in blood pressure and a drop in the amount of oxygen in the body. Mayo Clinic, *Dehydration: Complications* (2011), <http://www.mayoclinic.com/health/dehydration/DS00561/DSECTION=complications>.

¹⁴⁷ Interview with a hospital outpatient psychiatrist, August 2012.

¹⁴⁸ Testimony provided by the coordinator of the Human Rights Commission at the Hospital in August 2012, and by a psychiatrist in charge of forensic detainees in March 2012.

¹⁴⁹ Testimony provided to DRI by staff from Ward VI (geriatrics), March 2012.

¹⁵⁰ San Juan de Dios Hospital Records, 2010 and 2011.

¹⁵¹ According to a psychiatrist from Wards III and IV at the Hospital (August 2012), a former psychiatrist and an outpatient psychiatrist (March 2012), and a former sub-director at the Hospital (August 2011), patients have not been tested for HIV since at least 2008.

¹⁵² Interview with a hospital outpatient psychiatrist, August 2012.

¹⁵³ In March 2012, at least 10 patients (out of 40) had the flu in Ward II (acute men); these patients were mixed with the rest of the patients in overcrowded conditions. Information provided by the nurse from Ward II.

¹⁵⁴ See Annex XXX.

¹⁵⁵ Medical opinion of Mauricio Gómez, a Chilean psychiatrist and an international expert on mental health issues, during his visit to the hospital in March 2012.

man was never examined by a doctor. Ward staff eventually just placed him in a wheelchair and brought him back to his bed;¹⁵⁷

- a man from Ward II (acute men) informed Dr. Mauricio Gómez that his leg was causing him great pain. The patient said that nurses refused to pay any attention to his complaints. When Dr. Gómez attempted to examine the leg, the nurses prevented him from doing so. During the course of the DRI's visit to the hospital, this patient was never able to get any attention from staff despite his continued complaints;¹⁵⁸
- a woman in Ward III tried to escape by climbing up a metal door and got her head stuck at the top of the bars, creating a risk of strangulation; staff ignored her.¹⁵⁹
- the Human Rights Commission of the Hospital reported that in 2010, a woman did not receive medical attention for a broken arm for three days.¹⁶⁰

5. Exposure to HIV and lack of treatment

Numerous patients are known to be HIV positive¹⁶¹ and staff at the General Hospital report that they have discovered HIV when patients are transferred there for other reasons.¹⁶² Despite this, the hospital lacks exact information about how many people at the hospital are affected by the virus¹⁶³ and treatment for HIV people is not available.¹⁶⁴ Given the aforementioned, it can be concluded that no action is taken to prevent the spread of HIV, and patients are not generally tested to identify further risk. Given the widespread threats of sexual abuse at the hospital and the lack of supervision, there is a large risk that any patient may contract HIV.¹⁶⁵ Patients at the

¹⁵⁶ Observation made by Mauricio Gómez, a Chilean psychiatrist and an international expert on mental health issues, during his visit to the hospital in March 2012.

¹⁵⁷ Observed by DRI during its visit in March 2012.

¹⁵⁸ Observed by DRI during its visit in March 2012.

¹⁵⁹ Observed by DRI during its visit in March 2012.

¹⁶⁰ Human Rights Commission of the National Mental Health Hospital, *Report Number: CDHPEM-HNSM 002-2010* (February 1st, 2010). This document is addressed to the sub-director of the hospital. See Annex XX.

¹⁶¹ Petitioners have been informed of 7 cases of patients with HIV; specifically a chronic patient with an intellectual disability, a chronic woman, two acute women (one of them raped on the street) and three acute men (who were admitted this year). Information provided in August 2012 by the coordinator of the Human Rights Commission and by a social worker, a Hospital former psychiatrist, and a nurse from Ward I (acute women), and in March 2012 by a Hospital outpatient psychiatrist and a former psychiatrist.

¹⁶² Information provided by the Director of the San Juan de Dios General Hospital, a psychiatrist and a social worker from the emergency area of the San Juan de Dios General Hospital, August 2012. In this regard, in 2010 and 2011, three women that were referred to the general hospital and died, were suspected to be HIV positive. See Annex XXX, Records of Referrals from the Federico Mora Hospital (2010-2011).

¹⁶³ According to a psychiatrist from Wards III and IV at the Hospital (August 2012), a former psychiatrist and an outpatient psychiatrist (March 2012), and a former sub-director at the Hospital (August 2011), patients have not been tested for HIV since at least 2008, so the Hospital cannot know accurately how many patients with HIV there are.

¹⁶⁴ Information provided to DRI by a Hospital's former psychiatrist, September, 2012.

¹⁶⁵ According to information referred by an outpatient psychiatrist and the psychiatrist in charge of forensic detainees in March 2012, due to the large green areas at the Hospital, it is very difficult to know

Hospital that have been identified as HIV positive are not provided with assistance to ensure that they do not expose other sexual partners to infection.¹⁶⁶ For instance, a former psychiatrist reported that Juan, a patient with intellectual disabilities from Ward III who is HIV positive, has a sexual partner despite the lack of protection to ensure safe sex.¹⁶⁷ This former psychiatrist also referred the case of another HIV known positive female patient had also been seen having sex with a guard.¹⁶⁸ In this respect, staff from the Human Rights Ombudsman pointed out that “given that there is no type of control at the hospital, all the patients could have HIV.”¹⁶⁹

6. Lack of resources

In part, the lack of medical care is due to a shortage of resources. In addition to the shortage of psychiatric medications, there is a shortage of medicine for basic medical care, including antibiotics, anti-inflammatory medicine, and analgesics.¹⁷⁰ Basic necessities such as oxygen, albuterol for patients with asthma, or laryngoscopes are not available to treat patients in a medical emergency.¹⁷¹ There is also no X-ray machine at the facility,¹⁷² and no system or funding for detection or treatments of HIV.¹⁷³

7. Lack of emergency medical care

When a medical emergency occurs, the medical staff is insufficient to deal with it. Staff at the hospital report that this is especially a problem during the night shift and weekends when only one psychiatric resident and twelve technical staff (not trained nurses) are available to care for all 334 patients.¹⁷⁴ Furthermore, there is a serious lack of supplies and equipment to deal with any such emergency.

whether patients are having sexual relations. Moreover, according to Silvia Quan, there is no supervision at the Hospital so “anything can happen” (August 2012).

¹⁶⁶ Interview with a Hospital’s former psychiatrist, March 2012.

¹⁶⁷ *Ibidem*.

¹⁶⁸ *Ibidem*.

¹⁶⁹ Testimony provided by a Human Rights Ombudsman staff, August 2012.

¹⁷⁰ Information reported to DRI in August 2012 by the coordinator of the Hospital’s Human Rights Commission; and in March 2012, by two hospital psychiatrists, and a former psychiatrist. See also Human Rights Ombudsman, *Annual Report* (2007) p. 608; Human Rights Ombudsman Office, *Recommendation EIO-GUA-106-2002/DR May 13, 2012, “Considering”*; Prensa Libre, “Pacientes de Hospital viven atemorizado” (Patients at the Hospital Live in Fear) (June 6, 2010).

¹⁷¹ Interview with an outpatient psychiatrist and a former psychiatrist at the hospital, March 2012. See also Human Rights Ombudsman Office, *Recommendation REF.EXP.ORD.GUA.1441-2009/DESC July 19, 2010, “Results of the investigation”* (describing the lack of resources for essential medical care).

¹⁷² Information provided by nurses in Ward I (acute women), March 2012.

¹⁷³ Information provided to the ODHAG by authorities of the Area of Prevention and Treatment for HIV, TB and other contagious diseases, of the Penitentiary System of Guatemala, September 2012. Information also referred to DRI by a Hospital’s former psychiatrist, September, 2012.

¹⁷⁴ Information provided to DRI in March 2012 by the psychiatrist in charge of forensic detainees, an outpatient psychiatrist and a member of the hospital’s Human Rights Commission and in August 2011 by a former Hospital Sub-director.

In cases of emergency, patients can, in theory, be referred to the San Juan de Dios General Hospital.¹⁷⁵ Staff at the psychiatric hospital report that the general hospital arbitrarily refuses to take psychiatric patients transferred from Federico Mora¹⁷⁶ and they “return to the Federico Mora Hospital to die.”¹⁷⁷ For example, on June 29, 2012, Silvia Ochaeta, who suffered a brain stroke after she banged her head hard against an isolation room wall, was rejected from the general hospital because supposedly “nothing was wrong with her,” and died while she was being transferred to another hospital.¹⁷⁸ In August 2011, for example, a dying patient was sent to the San Juan de Dios Hospital; once the patient arrived, this Hospital would not receive her and the patient suffered a heart attack and died.¹⁷⁹ Staff at the General Hospital, in contrast, claim that patients are so neglected at Federico Mora that they are sent after any medical help is possible.¹⁸⁰ Medical staff at Federico Mora staff agree that many patients are sent to San Juan de Dios when they are near death – and many such patients never return.¹⁸¹ **Of the 38 cases that were referred to the San Juan de Dios Hospital in 2010 and 2011, 14 died.**¹⁸²

One of the main reasons for referral of patients to the San Juan de Dios General Hospital is because of overdose and intoxication.¹⁸³ In this respect, as mentioned previously, according to the records of patients sent from the Federico Mora Hospital to the general hospital in 2010 and 2011, seven patients were referred due to intoxication by medication; five of these patients died.¹⁸⁴ Patients are also referred to the general hospital due to complications of other diseases such as

¹⁷⁵ Information provided to DRI in March 2012 by a former psychiatrist at the hospital and three current staff members –two psychiatrists and a nurse from Ward I (acute women).

¹⁷⁶ Information provided by two current psychiatrists, an outpatient psychiatrist, a former psychiatrist, and a nurse from Ward I (acute women) in March 2012, and in August 2012, by the coordinator of the Hospital Human Rights Commission, a social worker, an outpatient psychiatrist and a San Juan de Dios Hospital psychiatrist.

¹⁷⁷ Testimony provided by an outpatient psychiatrist, August 2012.

¹⁷⁸ Information provided by a member of the Hospital Human Rights Commission, and by a Hospital nurse in August 2012.

¹⁷⁹ Interview with a nurse from the Hospital, August 2011.

¹⁸⁰ Information provided by a psychiatrist at the San Juan de Dios Hospital and by the Director of the Hospital Records in August 2012.

¹⁸¹ Information provided to DRI in March 2012 by a Hospital outpatient psychiatrist, a former psychiatrist, and a nurse from Ward VI (geriatrics).

¹⁸² San Juan de Dios Hospital Records, 2010 and 2011.

¹⁸³ Interview with the surgeon in charge of the Hospital records and a social worker from the emergency area at the San Juan de Dios Hospital, August 2012.

¹⁸⁴ San Juan de Dios Hospital Records, 2010 and 2011. Three of these patients had an alteration of their mental status of unknown etiology (cause). This mental alteration is most probably caused by overmedication of psychiatric drugs, among them, the antipsychotics. Moreover, the use of antipsychotics, especially Haldol, can cause the neuroleptic malignant syndrome (NMS) caused overmedication and negligence in the administration of antipsychotics (specifically Haldol). NMS can be fatal if untreated as it can cause cardiac dysrhythmias (which in turn cause the heart to beat too fast or too slow), as well as acute renal failure. See US Food and Drugs Administration, *Haldol brand of haloperidol injection (For Immediate Release)* (2011), p. 3, http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/015923s079lbl.pdf, [Last visit, June 30, 2012]; Mayo Clinic, *Heart Arrhythmias* (2011), <http://www.mayoclinic.com/health/heart-arrhythmias/DS00290> [Last visit August 22, 2012]. Medical observation made by psychiatrist and international expert on mental health, Mauricio Gómez (August, 2012).

pneumonia and diarrhea.¹⁸⁵ This is reflected in the fact that during 2010 and 2011, 7 patients with pneumonia and 3 with diarrhea were referred to the general hospital; out of these 10 patients, 5 died.¹⁸⁶ Furthermore, as already referred, in the same years 6 patients were referred with hematomas, fractures, or traumas;¹⁸⁷ according to staff from the San Juan de Dios Hospital, many of these cases are due to physical abuse.¹⁸⁸ With regards to the malnourished state of the patients, in 2010, a patient died at the general Hospital because of anemia.¹⁸⁹ Moreover, in 2010 and 2011, 15 patients were sent due to diverse medical complications, 4 women because of complications with their pregnancies, and one patient because of a suicide attempt.¹⁹⁰ It is worth mentioning, that in the mentioned years, three women that died were suspected to be HIV positive.¹⁹¹

F. Inhuman and degrading conditions

Unhygienic and filthy conditions prevail at the hospital¹⁹² to such an extent that the facilities can be described as a “sanitary disaster.”¹⁹³ A psychiatrist working on Wards III and IV (chronics) stated that “nobody should live in these conditions.”¹⁹⁴

The water that is available is unclean and unsuitable for drinking.¹⁹⁵ There is no hot water for showering.¹⁹⁶ There are shortages of supplies to clean the hospital,¹⁹⁷ and for personal hygiene.¹⁹⁸

¹⁸⁵ Interviews with staff from the San Juan de Dios General Hospital –specifically with the surgeon in charge of the Hospital records and with a social worker from the emergency area and with Hospital staff – with the Coordinator of the Hospital Human Rights Commission and a social worker, August 2012.

¹⁸⁶ San Juan de Dios Hospital Records, 2010 and 2011. Véase anexo XX.

¹⁸⁷ San Juan de Dios Hospital Records, 2010 and 2011. Véase anexo XX.

¹⁸⁸ Interview with the surgeon in charge of the San Juan de Dios Hospital records and a social worker (August 2012).

¹⁸⁹ San Juan de Dios Hospital Records, 2010 and 2011. Véase anexo XX. La anemia es causada por malnutrición. The body’s lack of nutrients to produce red cells leads to anemia in the patient. U.S. National Library of Medicine, *Health Topics: Anemia* (2011) <http://www.nlm.nih.gov/medlineplus/ency/article/000668.htm>

¹⁹⁰ San Juan de Dios Hospital Records, 2010 and 2011.

¹⁹¹ San Juan de Dios Hospital Records, 2010 and 2011.

¹⁹² Observed by DRI during its visits in August 2011, March 2012, and August 2012. This was also referred to DRI in March 2012, by an outpatient psychiatrist, a member of the Hospital’s Human Rights Commission, and a nurse in Ward III (chronic women); and in August 2011, by Hospital staff, including a former sub-director. See also Human Rights Ombudsman, *Annual Report* (2009), p. 226; International Disability Rights Monitor, *Regional Report on the Americas* (2004), p. 220; El Periódico, “The National Mental Health Hospital recovers at a slow pace” (February 4, 2009), <http://www.elperiodico.com.gt/es/20090204/pais/89483>.

¹⁹³ Testimony given by a member of the Hospital’s Human Rights Commission, March 2012.

¹⁹⁴ Testimony given by a psychiatrist from Wards III and IV, August 2012.

¹⁹⁵ Specifically patients drink water directly from the tap. Information provided by an outpatient psychiatrist and the coordinator of the Hospital’s Human Rights Commission, August 2012. DRI was also able to observe this during its visit, August 2012. In particular, DRI observed a patient, outside Ward V, who was taking water on a cup from a tap very close to the ground. Her water looked murky and not transparent. DRI pointed out to the Coordinator of the Hospital Human Rights Commission what was

There is no soap, shampoo, toothbrushes,¹⁹⁹ sanitary towels for the women,²⁰⁰ or diapers for the elderly or those with severe mental disabilities.²⁰¹ There is no toilet paper,²⁰² and “patients use newspaper if they are lucky.”²⁰³ The toilets do not receive any maintenance, are out of service, blocked or destroyed, and many of them are extremely dirty.²⁰⁴ Sinks do not work and sometimes the patients wash their hands in the washbasin “[where] everything gets washed, including the dishes.”²⁰⁵ There is no sink in Ward V.²⁰⁶ The patios, common areas, and wards are dirty and full of feces in the open.²⁰⁷ There are also puddles of urine in the mattresses.²⁰⁸

There is a lack of heaters during cold months,²⁰⁹ windows with broken or missing panes,²¹⁰ conditions of overcrowding,²¹¹ and poor ventilation on the residential wards.²¹² In March 2012,

happening, but the Coordinator did not give importance to this, and mentioned that patients are used to drinking the water that way.

¹⁹⁶ Information referred to DRI in March 2012, by a former Hospital psychiatrist, a patient from Ward I (acute women), a former patient and by Hospital staff – specifically an outpatient psychiatrist, a member of the Hospital’s Human Rights Commission, and a nurse from Ward VI (geriatrics).

¹⁹⁷ A cleaning staff member referred to DRI in August 2011, that she did not have items to clean with.

¹⁹⁸ Information referred to DRI in March 2012, by a nurse of Ward III (chronic women), a patient of Ward I (acute women), and a former patient. See also Disability Ombudsman, *Monitoring Report on the National Mental Health Hospital* (July, 2007), p. 9.

¹⁹⁹ Information referred by the Coordinator of the Hospital’s Human Rights Commission.

²⁰⁰ In this regard, one patient from Ward I (acute women) told DRI in March 2012, that “when I am menstruating there aren’t any sanitary towels and I don’t have any clean clothes.”

²⁰¹ Interview with an outpatient psychiatrist, August 2011.

²⁰² DRI corroborated a lack of toilet paper in the six functioning wards during its visit to the Hospital in March 2012. This information was also referred to DRI in March 2012, by an outpatient psychiatrist and a former patient and in August 2011, by a cleaning staff member.

²⁰³ Testimony provided by a Hospital cleaning staff, August 2011.

²⁰⁴ Observed by DRI during its visits in March 2012 and August 2012. Information also provided to DRI by a member of the Hospital’s Human Rights Commission in March 2012, and by the Disability Ombudsperson and a nurse from Ward I (acute women) in August 2012. See also Hospital Human Rights Commission, Report 06-2011 from the Complaints Records (March 8, 2011); Human Rights Ombudsman, *Annual Report: Human Rights Situation in Guatemala, Tomo 1* (2009), p. 226; Ombudsman Office, *Annual Report* (2009), p. 226; Defensoría de Personas con Discapacidad (2007), p. 9; Prensa Libre, “Desprecio por la salud” [Despise for Health] (Noviembre 24, 2011), http://www.prensalibre.com/opinion/Desprecio-salud_0_596940385.html.

²⁰⁵ Interview with nurse from Ward I (acute women), March 2012. See also Disability Ombudsman (2007), p. 9.

²⁰⁶ This was observed by DRI during its visit to the Hospital in August 2012.

²⁰⁷ This was observed by DRI during its visits to the Hospital in March and August 2012. In this respect, a nurse from Ward VI told petitioners in August 2012, that in the mornings, the Wards are full of feces and urine. See also Ombudsman Office, *Annual Report* (2009), p. 226.

²⁰⁸ This was observed by DRI during its visits to the Hospital in March and August 2012.

²⁰⁹ Information referred by a former psychiatrist in March 2012. During its visits to the Hospital in March and August 2012, DRI observed that there were no heaters in the Wards.

²¹⁰ During its visits to the Hospital in March and August 2012, DRI observed that there were numerous windows without glass in the Wards creating constant drafts and exposure to weather. This information was also reported by Silvia Quan, the Disability Ombudsperson, in March 2012.

DRI observed that elderly people in Ward VI (geriatrics) who were waiting to be bathed, with cold water, were naked and shivering.²¹³ According to Guatemala's Human Rights Ombudsman, the roof leaks and patients are forced to sleep on wet mattresses on the floor.²¹⁴ Many patients lack clothing, and the majority of the chronic patients do not have underwear.²¹⁵ Furthermore, patients' uniforms are full of feces and most of the patients are barefoot and smell bad.²¹⁶ Most female patients having closely cropped hair because of lice, fleas and a general lack of soap or shampoo.²¹⁷

Due to the overpopulation at the Hospital there is not enough space to house the patients,²¹⁸ and there are not enough beds.²¹⁹ On some wards, two patients are placed in one bed²²⁰ and in other areas, people are forced to sleep on mattresses on the floor;²²¹ furthermore several beds do not have mattresses²²² so the "patients sleep on ... wires."²²³ The shortage of beds has caused fights

²¹¹ See section II.F .

²¹² Interview with a nurse from Ward VI (geriatrics).

²¹³ Observed by DRI during its visit to the hospital in March 2012. See Annex XX.

²¹⁴ Interview with Silvia Quan (August 2012). Information reported to DRI by a physician from Ward I, and by two nurses in Ward II (acute men) in March 2012.

²¹⁵ This was observed by DRI during its visits to the Hospital in March and August 2012 and was referred to DRI by a Hospital outpatient psychiatrist in March 2012. See also Disability Ombudsman (2007), p. 9; Emisoras unidas 89.7, "Médicos del Federico Mora protestan por falta de insumos" [Hospital Federico Mora doctors protest for the lack of resources] (February 10, 2012).

²¹⁶ DRI observed this during its visits to the Hospital in August 2011 and March 2012. This was also referred to ODHAG in September 2012, and to DRI in March 2012 by an outpatient psychiatrist and a member of the Hospital's Human Rights Commission.

²¹⁷ Observed by DRI during its visits to the Hospital in August 2011 and March 2012. Ward nurses in "acute women" said they performed the hair cuts to reduce incidence of fleas and lice.

²¹⁸ Information provided by two psychiatrists in August 2011 and by Silvia Quan in August 2012. See also Human Rights Ombudsman, *Recommendation REF.EXP.ORD.GUA.1441-2009/DESC* July 19, 2010, "Investigation results;" Human Rights Ombudsman Office, *Annual Report* (2009), p. 227.

²¹⁹ Information referred to DRI in August 2012, by the Coordinator of the Hospital Human Rights Commission, a social worker, and by Silvia Quan, the Disability Ombudsperson. In August 2012, there were 52 patients in Ward II (acute men), which only had 40 beds. A member of the Hospital's Human Rights Commission and a former psychiatrist stated in an interview with DRI in March 2012, that on occasion there are 70 people in a ward with 40 beds. The Hospital's Human Rights Commission also reported overcrowding in Ward V in March 2011, noting that there were 67 patients for 45 beds; see Hospital Human Rights Commission, *Report 06-2011 from the Complaints Records* (March 8, 2011).

²²⁰ Information provided to DRI in August 2011, by two psychiatrists.

²²¹ During its visit to the Hospital in March 2012, DRI staff confirmed that there were mattresses on the floor for patients who did not have beds. Likewise, information in this regard was referred to DRI in March 2012, by current staff at the Hospital –specifically an outpatient psychiatrist, a member of the Hospital's Human Rights Commission, and a nurse of Ward II (acute men); by a former psychiatrist; a member of REDNOVI; and by Silvia Quan, the Disability Ombudsperson.

²²² Hospital Human Rights Commission, *Report 06-2011 from the Complaints Records* (March 8, 2011). See also Emisoras unidas 89.7, "Médicos del Federico Mora protestan por falta de insumos" [Doctors at the Hospital Federico Mora protest for the lack of resources] (February 10, 2012), <http://noticias.emisorasunidas.com/category/etiquetas/federico-mora>; Prensa Libre, "Desprecio por la

among patients.²²⁴ The available beds are old and in extremely poor conditions, often torn and stained.²²⁵ DRI investigators observed many mattresses with puddles of urine in them.²²⁶ There is a lack of sheets, blankets, and pillows for the beds.²²⁷

The poor physical conditions at Federico Mora are inhuman and degrading – and they contribute to the immediate threat to health and life for people detained at the facility. Poor sanitary conditions lead to the spread of infectious diseases, including pneumonia, as well as gastrointestinal infections.²²⁸

The limitations of movement for acute women (locked in Ward I to protect them from sexual abuse) contributes to overcrowding and inactivity.²²⁹ During the day, these women sleep or lie in bed or sit down doing nothing, without any diversion or recreation except a television which is occasionally turned on. Some of the women walk back and forth continuously along the Ward's corridor.

Persons with intellectual disabilities are particularly neglected and left in barren areas, some half-naked.²³⁰ Ten women with intellectual disabilities in Ward III (chronic women) and eight men with intellectual disabilities in Ward IV (chronic men) are locked in two outdoor patios of their Ward all day long, supposedly for their own protection.²³¹ Inactivity, lack of stimulation, and degrading conditions contribute to their intellectual disabilities. Most of the outdoor patios where persons with disabilities are locked, lack roof, leaving them with long-term sun exposure that creates very real physical risks.²³² During DRI's visit in March 2012, we observed the women locked in the patio of Ward III doing nothing. One of these women was partially undressed, had injuries on her face and body, and was crying out of desperation. This woman was striking the door to get out;

salud" (November 24, 2011); Noti 7, noticias al instante, "National Mental Health Hospital completely collapsed" (November 16, 2011).

²²³ Testimony given to DRI in March 2012, by the coordinator of the Hospital's Human Rights Commission.

²²⁴ Information provided to DRI in August 2012, by a social worker from Ward V.

²²⁵ Observed by DRI in March and August 2012. See also Hospital Human Rights Commission, Report 06-2011 from the Complaints Records (March 8, 2011); Disability Ombudsman, *Monitoring Report on the National Mental Health Hospital* (July, 2007), p. 6; Prensa Libre, "Desprecio por la salud" (November 24, 2011).

²²⁶ See Annex XX.

²²⁷ Information referred to DRI in March 2012, by a Hospital outpatient psychiatrist and by a former patient of Ward I (acute women). See also Disability Ombudsman, *Monitoring Report on the National Mental Health Hospital* (July, 2007), p. 9.

²²⁸ Interviews with a nurse from Ward IV, an outpatient psychiatrist, and the coordinator of the Hospital's Human Rights Commission, August 2012.

²²⁹ Testimony provided by the coordinator of the Hospital's Human Rights Commission, August 2012. During its visits to the Hospital in March and August 2012, DRI corroborated that women in this ward were locked in and that there was overcrowding.

²³⁰ Observed by DRI during its visit in March 2012.

²³¹ Interview with a nurse from Ward III (chronic women), March 2012.

²³² Observation made by Mauricio Gómez, a Chilean psychiatrist and an international expert on mental health, during this visit to the Hospital with DRI in March 2012. See also Annex XX.

her eye was injured and she informed us that she had been assaulted.²³³ Another woman was trying to escape by climbing the metal bars of the patio's door. She repeatedly got her head stuck in the space between the bars and the roof, creating a risk of strangulation if she fell. Hospital staff never responded to this potential danger.²³⁴

G. Lack of food and drinking water

Staff at Federico Mora and the General Hospital report that patients at Federico Mora have died of malnutrition and related health problems.²³⁵ According to the San Juan de Dios Hospital records, in 2010, a patient that was referred from the Federico Mora Hospital died because of anemia.²³⁶ The drinking water at the hospital is not potable, and the patients drink water directly from the tap.²³⁷ Due to the fact that many of these faucets are very close to the floor, when the patients drink the water, they come in direct contact with the unhygienic conditions of the facilities.²³⁸ In fact, the contaminated water is the main reason for the high incidence of diarrhea among the patients.²³⁹

The food at the Hospital is of poor quality, and the portions are very small.²⁴⁰ Patients constantly complain of being hungry.²⁴¹ Given the poor hygiene of the hospital, the food cannot be prepared and distributed in sanitary conditions.²⁴² This results in gross deficiencies and failure to meet minimum dietary guidelines and nutritional requirements of the Pan American Health Organization (PAHO).²⁴³

²³⁴ Observed by DRI during its visit to the Hospital in March 2012. See Annex XX.

²³⁴ Observed by DRI during its visit to the Hospital in March 2012. See Annex XX.

²³⁵ Interview with a psychiatrist and a social worker of the San Juan de Dios General Hospital, that work at the emergency room, August 2012.

²³⁶ San Juan de Dios Hospital Records, 2010 and 2011.

²³⁷ Testimony provided by an outpatient psychiatrist and the coordinator of the Hospital's Human Rights Commission, August 2012.

²³⁸ DRI observed this during its visit, August 2012. In particular, DRI observed a patient, outside the Ward V, who was taking water on a cup from a tap very close to the ground. Her water looked murky and not transparent. DRI pointed to the Coordinator of the Hospital Human Rights Commission what was happening, but the Coordinator did not give importance to this, and mentioned that patients are used to drinking the water that way.

²³⁹ Testimony provided by an outpatient psychiatrist at the Hospital, March 2012.

²⁴⁰ Interview with the Coordinator of the Hospital Human Rights Commission, a social worker, and with Silvia Quan, the Disability Ombudsperson, August 2012. Information also provided to DRI in March 2012, by a member of the Hospital's Human Rights Commission, a Hospital former psychiatrist, two patients at the Hospital, and a former patient; and in August 2011, by an outpatient psychiatrist.

²⁴¹ Information referred to DRI by a general doctor and by the person in charge of distributing the food at the Hospital, in August. This information was also provided by an outpatient psychiatrist and a former patient in March 2012.

²⁴² Interview with Silvia Quan, the Disability Ombudsman, August 2012.

²⁴³ Pan American Health Organization, Institute of Nutrition of Central America and Panama, *Food-based dietary guidelines and health promotion in Latin America*, April 1999, p. 9.

There is no cutlery in the hospital, and the food is served directly on plastic trays.²⁴⁴ “The majority of patients eat with their hands”²⁴⁵ sin poder lavarlas por la falta de jabón y lavabos funcionales.²⁴⁶

H. Risk of fire due to poor electrical wiring

The patient’s lives are threatened by the serious state of deterioration of the electric wiring at the Hospital.²⁴⁷ According to a Hospital electrician, “given the deterioration of the electricity supply network, there is a risk of fire due to a short circuit [...] it is a latent risk for patients and staff.”²⁴⁸ Además, el riesgo de corto circuito también puede presentarse cuando el agua que se filtra por los pabellones entra en contacto con los cables expuestos.²⁴⁹ This imminent risk of fire is aggravated by the fact that there are no fire extinguishers in any of the Hospital Wards.²⁵⁰ Numerous hospital staff commented that the only plan for an evacuation in the case of fire (or other emergency) was to run for the main exit, expressing a preoccupation for their own safety as well as that of the patients in the case of such an event.²⁵¹

III. APPLICABLE LAW

To establish the urgency to adopt precautionary measures to protect the entire population of Federico Mora we will demonstrate that the case of the 334 patients, meets all of the requirements, prescribed under the Rules of Procedure of the IACHR for awarding these measures: (1) the gravity and urgency of the situation, the context and the imminence of the harm in question; (2) whether the situation of risk has been brought to the attention of the pertinent authorities; (3) the identification of the potential beneficiaries, and (4) their express consent. Finally, we will reference the precautionary and provisional measures which relate to facts similar to those of the present application.

A. Gravity, urgency, and risk of irreparable and imminent harm

²⁴⁴ Observed by DRI during its visit to the Hospital in March 2012. This information was also referred to DRI in March 2012, by an outpatient psychiatrist and by a nurse from Ward I (acute women).

²⁴⁵ Testimony provided by an outpatient psychiatrist at the Hospital, March 2012. This was also referred to DRI in August 2011, by an outpatient psychiatrist and a former sub-director at the Hospital.

²⁴⁶ Véase sección II.F

²⁴⁷ Information referred to DRI by a member of the Hospital Human Rights Commission in March 2012. Desde 2007 el Disability Ombudsman ya señalaba el deterioro del sistema eléctrico. Ombudsman Disability, Monitoring Report on visit to the Hospital Federico Mora (2007), p. 6.

²⁴⁸ Hospital Human Rights Commission, Report 06-2011 from the Complaints Records (March 8, 2011). This information was also referred to DRI in August 2012 by Silvia Quan, the Disability Ombudsperson.

²⁴⁹ Información referida a ODHAG por una enfermera del pabellón I, marzo de 2012.

²⁵⁰ This information was referred to DRI by two nurses from Ward II, August 2012.

²⁵¹ Information provided by nurses and staff in the men’s chronic Ward, DRI Visit August 2012,

1. The situation of the 334 patients is grave

Regarding the issue of gravity for the purpose of adopting provisional measures, the Convention requires that it be “extreme,” that is, that it be in its most intense or elevated degree.²⁵² In the instant case, the gravity and intensity of the situation results from the fundamental character of the rights in jeopardy – the right to life and personal integrity – as well as from the context of total vulnerability in which the 334 patients, find themselves, lacking juridical capacity or any other means to defend themselves from these threats to their lives and persons.

The Inter-American Court has accepted that the fundamental nature of a right, such as freedom of the press, may justify awarding provisional measures.²⁵³ In this case, the right to life and personal integrity is at risk. The right to life is of the most fundamental nature, as established by the Inter-American Court, “[t]he right to life is a fundamental human right, and the exercise of this right is essential for the exercise of all other human rights.”²⁵⁴ For this reason the Inter-American Court has on several occasions awarded provisional measures to protect people whose lives and personal integrity were threatened.²⁵⁵

Based on all the facts presented in this application, and given the daily abuse to which any person detained at the Hospital Federico Mora is exposed to –whether or not that person has a disability– is at risk of serious injury or death . Due to their special needs, individuals with disabilities are at even greater risk in the facility than non-disabled individuals.²⁵⁶

2. The situation of the 334 patients, is urgent

²⁵² Inter-American Court. *Matter of Belfort Istúriz and others*, Request For Provisional Measures Submitted by The Inter-American Commission On Human Rights Regarding Venezuela, April 15, 2010, considering clause 8.

²⁵³ Inter-American Court. *Matter of Belfort Istúriz and others*, Request For Provisional Measures Submitted By The Inter-American Commission On Human Rights Regarding Venezuela, April 15, 2010, considering clause 11 and 14.

²⁵⁴ Inter-American Court. *Case of the “Street Children” (Villagrán-Morales et al.)*. November 19, 1999. Series C No. 63, para. 144.

²⁵⁵ *inter alia*: Inter-American Court of Human Rights. *Matter of Pueblo Indígena Sarayaku*, Provisional Measures regarding Ecuador. Order of the Court. July 6, 2004; Inter-American Court of Human Rights. *Case of Mack Chang et al.* Provisional Measures regarding Guatemala. Order of the Court, January 26, 2009; Inter-American Court. *Case of El Rodeo I and El Rodeo II Judicial Confinement Centre*, Provisional Measures regarding Venezuela. Order of the Court. February 8, 2008.

²⁵⁶ In relation to the vulnerability of persons with mental disabilities, the Inter-American Court has signaled that due to their psychological and emotional condition, the high degree of intimacy involved in treating psychiatrist illness, and the imbalance of power between patients and medical staff, minors and adults with this disability are particularly vulnerable when they are admitted to mental health institutions. In fact, this Court has established that these persons “are particularly vulnerable to torture and other types of cruel, inhuman or degrading treatment.” See Inter-American Court of Human Rights, *Ximenes Lopes*, paras 106, 129 and 140.

According to the Inter-American Court, “the characteristic of urgency implies that the risks or threats involved are imminent, and require an immediate response to resolve them.”²⁵⁷ In the present case the risk of threat or damage is not only imminent, but has already begun to materialize in the form of deaths, illnesses, and severe physical and sexual abuse of the patients at the hospital. In other instances where a situation of risk had already materialized, the Court has deemed the requirement of urgency as satisfied.²⁵⁸

The 334 patients at the hospital are exposed to numerous threats to life and personal integrity, and many have already suffered serious harm, even died, from the enumerated conditions and attendant risks described throughout this petition. Until measures are taken to protect the lives and integrity of these patients, the situation will continue to be urgent and the prospects of avoiding or repairing harm will be inversely proportional to the passage of time.

3. The 334 patients risk suffering irreparable harm

Thirdly, the 334 patients run the risk of suffering irreparable harm. The Inter-American Court has said regarding this harm that “there should exist a reasonable probability that the harm will materialize and the harm should not fall on goods or juridical interests which can be repaired.”²⁵⁹ Regarding the harm being irreparable, the harm being discussed in the present case is harm to the personal integrity of all the patients at the Federico Mora Hospital, and the high probability of losing their lives. The loss of life, the suffering of a terminal illness, disfigurement or mental harm caused by the serious and grave abuses they are victims of, fall on goods or juridical interests which can never be fully undone or repaired.

Regarding the probability of the harm materializing, as demonstrated above, much irreparable harm has already befallen the patients at the Federico Mora; the extent of harm already occurred demonstrates the real and concrete risk that exists that the 334 patients will continue to suffer further, irreparable harm.

²⁵⁷ Corte I.D.H. *Asunto Belfort Istúriz y otros*, Solicitud de medidas provisionales presentada por la Comisión Interamericana de Derechos Humanos respecto de Venezuela, considering clause 8.

²⁵⁸ Inter-American Court. *Matter of L.M.* Provisional Measures with regard to Paraguay. Order of the Court. July 1, 2011; Inter-American Court. *Matter of Belfort Istúriz and others*, Request For Provisional Measures Submitted By The Inter-American Commission On Human Rights Regarding Venezuela, April 15, 2010.

²⁵⁹ Corte IDH. *Asuntos Internado Judicial de Monagas (“La Pica”), Centro Penitenciario Región Capital Yare I y Yare II (Cárcel de Yare), Centro Penitenciario de la Región Centro Occidental (Cárcel de Uribana), e Internado Judicial Capital El Rodeo I y el Rodeo II*. Provisional measures with regards to Venezuela. Court Resolution from November 24, 2009, thirty considering; *Wong Ho Wing*. Provisional measures with regards to Peru. Court Resolution from May 28, 2010, sixth considering, and Case *De La Cruz Flores v. Perú*. Supervision or fulfillment with the judgment and Provisional Measures. Court’s Resolution from September 1, 2010, seventieth second considering.

Consequently, the precautionary measures in favor of the 334 patients at the Federico Mora Hospital are necessary because of the grave and urgent situation and the real, concrete and specific risk that the patients will suffer irreparable harm.

B. Fulfillment of the additional criteria for awarding precautionary measures (art. 25.4 of the rules of procedure).

1. Whether the situation of risk has been brought to the attention of the pertinent authorities or the reasons why it might not have been possible to do so

In order to demonstrate that the State of Guatemala failed to respond appropriately to stop this pattern of human rights violations against people with disabilities admitted to the Federico Mora Hospital, we will demonstrate that: a) the State has knowledge of the serious pattern of violations; b) the authorities' inability and inactivity to stop these abuses; and c) the reasons that complaints have not been lodged against authorities by the potential beneficiaries.

a. Knowledge by the Guatemalan state on the pattern of serious and grave human rights violations taking place in the Hospital Federico Mora

Since at least 2002, through national decisions and international recommendations contained in various reports, the Guatemalan state has been aware of the pattern of serious and grave human rights violations perpetrated against people with mental disabilities detained in the Federico Mora Hospital.²⁶⁰ Furthermore, the conditions which threaten the lives and personal integrity of these

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Specifically, the government is aware of the following facts, as of at least the indicated years:

- Direct contact between the patients and the forensic detainees, which increases the risk that patients suffer abuse by the latter, since 2002. Human Rights Ombudsman, *Recommendation EIO-GUA-106-2002/DR*, May 13, 2002, "considering" point (c);
- Risk of abuse against staff by forensic detainees, since 2002. Human Rights Ombudsman, *Recommendation EIO-GUA-106-2002/DR*, May 13, 2002, "Diligence performed and reports received" point 3;
- Presence of guards at the hospital carrying their firearms visibly –representing a danger to patients and staff—since 2002. Human Rights Ombudsman, *Recommendation EIO-GUA-106-2002/DR*, May 13, 2002, "Considering" point (d).
- Transfer of forensic detainees who do not have a mental disability to the hospital and lack of judicial interest to follow-up these cases since 2002. Human Rights Ombudsman, *Recommendation EIO-GUA-106-2002/DR*, May 13, 2002.
- Failures in the electric wiring, since 2007. Disability Ombudsman, *Monitoring Report of the National Mental Health Hospital* (2007), p. 6;
- Inhumane and degrading living conditions of the patients, since 2002. Human Rights Ombudsman, *Recommendation EIO-GUA-106-2002/DR*, May 13, 2002, "Diligence performed and reports received" point 1;
- Overcrowding of the patients, since 2007. Public Defender of People with Disabilities, *Monitoring Report* (2007), p. 9; Shortages of personal hygiene supplies, and lack of clothing for the patients since 2007. Disability Ombudsman, *Monitoring Report of the National Mental Health Hospital* (2007), p. 9;

people are public knowledge, having been described and reported in various news stories from 2002 through the present date.²⁶¹

At the national level, the Human Rights Ombudsman Office has published several recommendations in which it denounced the human rights violations perpetrated against the patients at the Federico Mora, and recommended that Guatemalan authorities take the necessary measures to respect and guarantee the rights of the patients.²⁶² In this vein, the Human Rights Ombudsman Office as well as the Disability Ombudsman have reported on the situation at the hospital in their yearly reports.²⁶³

At the international level, various reports have also exposed the grave conditions in which the patients at the Federico Mora Hospital live. Among these reports, it is worth highlighting the report by the International Disability Rights Monitor (2004),²⁶⁴ the UN Special Rapporteur on Disability's Report on the Visit to Guatemala (2004)²⁶⁵ and the Report by the UN Special Rapporteur on the right to health on his visit to Guatemala (2011).²⁶⁶ In 2004 the UN Rapporteur

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- Deterioration of the toilets and sinks, as well as of beds and mattresses; the latter can have serious effects on the patient's health, since 2007. Disability Ombudsman, *Monitoring Report of the National Mental Health Hospital* (2007), pp. 6 & 9;

²⁶¹ Annex X.

²⁶² Regarding the referred resolutions of the Human Rights Ombudsman, it is worth highlighting the following:

- Recommendation of the Human Rights Ombudsman (PDH), January 27 2012, directed at the General Direction of the National Penitentiary System and the National Civil Police – for violations of the human rights of the forensic detainees by both agencies. Reference: EXP.EIO.GUA.2595-2009/DE. Annex XX
- Recommendation of the PDH, July 19 2010, directed at the Ministry of Public Health and Social Assistance, for the violation of the right to health on account of the poor quality of medical services offered at the hospital. Reference: EXP.ORD.GUA.1441-2009/DESC. Annex X.
- Recommendation of the Human Rights Ombudsman (PDH), May 13 2002, directed to the Ministry of Public Health and Social Assistance, the Ministry of Interior and the Direction of the National Civil Police, for the grave human rights violations against patients and forensic detainees at the hospital. EIO-GUA-106-2002/DR. Annex XXX.

²⁶³ Human Rights Ombudsman, *Annual Report: Situation of Human Rights in Guatemala*, Volume 1 (2009), pp. 226-227,

http://www.pdh.org.gt/index.php?option=com_phocadownload&view=category&id=8&Itemid=44; Disability Ombudsman, *Monitoring Report of the National Mental Health Hospital* (2007); Human Rights Ombudsman, *Annual Report: Situation of Human Rights in Guatemala*, Volume 1 (2007), p. 608, http://www.pdh.org.gt/index.php?option=com_phocadownload&view=category&id=8&Itemid=44

²⁶⁴ International Disability Rights Monitor, *Regional Report on the Americas* (2004), p. 220 http://www.ideanet.org/cir/uploads/File/IDRM_Americas_2004.pdf

²⁶⁵ United Nations Special Rapporteur on Disability, *Report on the Visit to Guatemala* (2004), http://www.srdisability.org/regions/latin_america/guatemala/report_oct04.html.

²⁶⁶ Special Rapporteur on the right of all persons to enjoy the highest possible level of physical and mental health, "Addition: Mission to Guatemala", in *Report of the Special Rapporteur regarding the right of*

on Disability stated that “persons with psycho-social disabilities are having their human rights violated on a daily and continuous basis at the hospital [Federico Mora].”²⁶⁷ In the follow up to this report in 2005, the Rapporteur concluded that “its recommendations had not been acted on and the conditions at the hospital remained the same”.²⁶⁸ In 2011, the UN Special Rapporteur on the Right to Health considered the mental health sphere in Guatemala as critical and in need of important improvements.²⁶⁹

Given the established knowledge of the Guatemalan state of the grave and serious human rights violations perpetrated against the people with disabilities in the Federico Mora Hospital – evidenced by the recommendations from the government's own Human Rights Ombudsman's Office and from international organizations, as well as news stories– the state of Guatemala has completely ignored its obligations to respect and guarantee the human rights of the hundreds of people with mental disabilities who are interned in the hospital.

b. The authorities' inability or inactivity to stop these abuses

- i. The Hospital authorities have been unable or have failed to denounce and to stop the abuses committed against patients.

In regard to the Hospital authorities' response, a psychiatrist pointed out that “their passive attitude is draining.”²⁷⁰ Regarding the complaints about the abuses committed by guards, the Disability Ombudsperson asserted that such complaints often receive no follow-up nor do the Hospital authorities rarely inform the relevant authorities, because Hospital authorities are afraid of the reprisals that guards can take against them, given that in various occasions they have been intimidated.²⁷¹ Neither an external consultation psychiatrist nor a psychiatrist from Wards III and IV, in the five and twelve years that they have worked in the Hospital, respectively, have ever been aware of any guard being sanctioned for the serious abuses committed against the patients.²⁷²

On many occasions, the aggressions committed against patients are not brought to the attention of the Hospital's authorities because staff know that nothing will be done about it, and because

all persons to the highest possible level of physical and mental health (2011), http://www.osarguatemala.org/userfiles/Relator%20Salud_Mision%20a%20Guatemala_mayo2010.pdf.

²⁶⁷ United Nations Special Rapporteur on Disability, *Report on the Visit to Guatemala* (2004), p. 12, http://www.srdisability.org/regions/latin_america/guatemala/report_oct04.html.

²⁶⁸ *Ibid* p. 14

²⁶⁹ Special Rapporteur on the right of all persons to enjoy the highest possible level of physical and mental health, “Addition: Mission to Guatemala”, in *Report of the Special Rapporteur regarding the right of all persons to the highest possible level of physical and mental health* (2011), para 14, http://www.osarguatemala.org/userfiles/Relator%20Salud_Mision%20a%20Guatemala_mayo2010.pdf.

²⁷⁰ Interview with an outpatient psychiatrist, August 2012.

²⁷¹ Interview with Silvia Quan, August 2012.

²⁷² Testimony provided by an outpatient psychiatrist and by a psychiatrist from Ward III and IV, August 2012.

staff is afraid to denounce the abuses committed by the guards, for fear of reprisals.²⁷³ This fear of reprisal is not unfounded; staff members who reprimand the guards for their conduct towards patients have been threatened and on occasion assaulted.²⁷⁴ For example on Wednesday, August 8, 2012, a doctor surprised a guard touching a patient in the acute ward (Ward I), but decided not to report it because of the guard's threats.²⁷⁵ Regarding this situation, the psychiatrist from Wards III and IV pointed out that "in the hospital we are very afraid of reporting the guards because they carry arms, and because we cannot identify them."²⁷⁶

In relation to the complaints of abuses committed by staff members, the authorities also do not take action to sanction or stop them, due to a lack of interest, as well as the difficulty in firing offending staff members because of union procedural protections,²⁷⁷ or due to fear of retaliation by offending or other staff some of whom have links to criminal groups, such as the *Mara Salvatrucha*.²⁷⁸ In one such situation a nurse seriously injured a patient in December 2011, but because he was associated with the *Mara Salvatrucha*, he was not sanctioned in any way, nor did authorities inform the Public Ministry about the incident.²⁷⁹

Furthermore, a psychiatrist that has been working in the hospital for 5 years, and another one that has been working for 12, expressed that during the time they have been at the Hospital, they have not seen abusive staff being "really" punished.²⁸⁰ In the cases that they have "punished" the staff, the disciplinary measures are disproportionately light in view of the severity of the violation.²⁸¹

Similarly, patients are also afraid to speak out about abuses because staff intimidate and even abuse them. For instance, according to a former psychiatrist, a patient from Ward II (acute men) was beaten up the morning after he complained about a nurse who, to wake the patient up, had thrown him out of bed.²⁸² This patient reported the incident to a psychiatrist who in turn reported

²⁷³ Information provided to DRI in August 2012 by a psychiatrist from Ward III and IV, and by a nurse from Ward III in August 2012. This information was also referred in March 2012 by a former psychiatrist, by the Coordinator of the Hospital Human Rights Commission and a social worker, by a nurse from Ward III (March, 2012) and by Silvia Quan (March and August, 2012).

²⁷⁴ Interviews with Silvia Quan and with member of the Hospital Human Rights Commission, August 2012. See also Human Rights Ombudsman, *Annual Report* (2009), p. 227.

²⁷⁵ Interview with a psychiatrist from Ward III and IV. Específicamente señaló que el guardia amenazó a la doctora con hacerle lo mismo que le hizo a la paciente. Information also referred by a member of the Hospital Human Rights Commission, August 2012.

²⁷⁶ Interview with a psychiatrist from Ward III and IV, August 2012.

²⁷⁷ Testimony provided to by Silvia Quan in March 2012.

²⁷⁸ Interview with the psychiatrist in charge of the forensic detainees and the coordinator of the Hospital Human Rights Commission and a social worker, August 2012.

²⁷⁹ Interview with a psychiatrist from Wards III and IV, the Coordinator of the Hospital Human Rights Commission and a social worker, August 2012.

²⁸⁰ Testimony provided by an outpatient psychiatrist and by a psychiatrist from Ward III and IV, August 2012.

²⁸¹ Testimony provided by a psychiatrist from Ward III and IV, August 2012

²⁸² The patient complained to a psychiatrist who reported this incident to the hospital administration. The administration did not to anything in this regard; what is more, as a reprisal to the psychiatrist who

it to the Hospital administration; the Hospital administration did not take any action regarding the incident and what is more, as a reprisal to the psychiatrist that had complained, the nurses of Ward II (acute men) refused to shower the patients for a week and a half.²⁸³ DRI staff was also able to observe incidences of patient intimidation by the staff; when a patient from Ward II complained to us of a pain in his leg, a nurse responded very aggressively to the patient, screaming at him to stop lying.²⁸⁴

A clear example of the State's failure to protect and guarantee the life and personal integrity of two persons with disabilities who are directly under its care and custody, is the inactivity shown in the cases of the patients Erick Hernández y José Geovanni Hernández. On Thursday, August 23, 2012, the ODHAG filed two complaints in which it informed both, the Director of the Hospital Federico Mora and the Minister of Health, of the perilous state of health of the two patients that attempts against their lives and integrity, and requested both authorities to provide them adequate treatment according to their needs.²⁸⁵ According to the information reported by hospital staff interviewed on September 20, 2012, to date – that is almost a month and a half after the filing of the remedies— the relevant authorities have taken no adequate action in order to protect the health of Jose Geovanny Hernández and Erick Hernández “because of a lack of resources.”²⁸⁶ Also, the ODHAG has not received any official communications from either the Director or Ministry of Health as of today. This is alarming considering that the negligent care provided to both individuals has caused them severe medical complications, which undoubtedly threaten against their personal integrity, and that at any time could result in the loss of life of any of these patients.

- i. Lack of effectiveness of complaints and the inaction by the Police, the Public Ministry, and the Penitentiary System

According to information given by hospital staff, it is rare that Hospital authorities file complaints when abuses take place. On limited occasions, when complaints for physical and sexual abuse have been submitted to other institutions –such as the Public Ministry and the Chief of Police—no action has been taken with respect to these complaints.²⁸⁷ For example, the former sub-director filed a complaint in 2010 before the Chief of Police, arguing that acute female patients were performing oral sex on the guards at night but the police response was limited to filing a single a report, and no other actions - prevention, investigation or sanction – were taken to stop these abuses.²⁸⁸

complained, the nurses refused to bathe the male patients of Ward II (acute) for a week and a half. Information provided to DRI by a Hospital former psychiatrist, March 2012.

²⁸³ Information provided to DRI by a Hospital former psychiatrist, March 2012.

²⁸⁴ Observed during DRI's visit to the Hospital in March 2012.

²⁸⁵ See Annex XX, Complaints by ODHAG presented to the Director of the Hospital Federico Mora and the Minister of Health, August 23, 2012.

²⁸⁶ Information provided to ODHAG by the coordinator of the hospital's human rights commission, September 2012.

²⁸⁷ Interview with a psychiatrist from Ward III and IV, August 2012, the Coordinator of the Hospital Human Rights Commission and a social worker, August 2012.

²⁸⁸ Interview with the psychiatrist in charge of the forensic detainees at the Hospital, March 2012.

Moreover, the lack of response from the National Civil Police and the penitentiary system to end or punish abuses committed by guards against the patients in Federico Mora Hospital, is also reflected in the non-fulfillment of recommendations issued by the Human Rights Ombudsman.²⁸⁹ For example, in a recommendation issued on January 27, 2012, this Ombudsman found that in spite of the fact that the General Directorate of the Penitentiary System stated that it was committed to applying the corresponding sanctions to guards who had violated patients' rights in 2009, "the events that led to the opening of the case ... still continue."²⁹⁰ The Human Rights Ombudsman's Office has also condemned the attitude of the National Civil Police Director for not responding to an information request regarding the disciplinary measures applied to guards that have committed abuses against the patients.²⁹¹

c. Reasons why complaints have not been lodged against authorities by the potential beneficiaries

According to article 308 of the Guatemalan Civil Code, the director of any institution which admits "the disabled" is the guardian and legal representative of such persons from the moment of their admission to the facility, without the need for any process or review.²⁹² In the present case therefore, the director of the Federico Mora is the guardian and legal representative of all the 334 patients, and is in charge of their care.²⁹³ Therefore the legal capacity of each of these 334 patients to engage in legal proceedings rests with the Director. The 334 patients have no direct access to judicial recourses to challenge their internment or complain of the abuse perpetrated against them. . The person who would have to act in their interest – that is to say their tutor – is the same person who has been negligent in protecting their rights and interests. The current case closely resembles that of *Stanev v. Bulgaria* (2012), where the European Court of Human Rights established that institutionalized persons with mental disabilities must have the right to bring action to protect their own rights.²⁹⁴ Guatemalan law permitting people with disabilities to be automatically stripped *de facto* of their legal capacity, without any judicial or administrative procedure, and without making efforts to provide support for their right to make decisions, is also a clear violation of article 3 of the American Convention and article 12 of the CRPD.

²⁸⁹ Interview with Silvia Quan, August 2012. En relación con las recomendaciones emitidas por la Procuraduría sobre estas cuestiones, véase Anexo XX.

²⁹⁰ PDH, *Recomendación REF.EXP.ORD.GUA. 2595–2009/DE 27 de enero de 2012*, "Resultado de la Investigación." Despite the fact that the Penitentiary System General Director committed himself to rigorously sanction those guards that violated the patient's rights

²⁹¹ PDH, *Recomendación EIO-GUA-106-2002/DR de 13 de mayo de 2002*, "Resoluciones," La Hora, "PDH censura a policías por vejámenes contra enfermos mentales" (Junio 18, 2002).

²⁹² Civil Code, Law Decree 106, available at <http://biblio3.url.edu.gt/Libros/2011/codigo.pdf>. In the practice, this was reinforced by the testimony provided by an outpatient psychiatrist, August 2011. See also International Disability Rights Monitor (2004), p. 220.

²⁹³ Article 293 of the Civil Code of Guatemala

²⁹⁴ See European Court of Human Rights, Grand Chamber, *Stanev v. Bulgaria* (January 17, 2012). <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-108690>.

2. The individual identification of the potential beneficiaries of the precautionary measures or the identification of the group to which they belong.

In the instant case, the potential beneficiaries of the precautionary measures belong to all persons detained in the Federico Mora Hospital – whether or not such individuals have actual disabilities. In order to ensure that people with disabilities have the same protections as all other individuals, reasonable accommodations for their protection are needed.²⁹⁵

3. The express consent of the potential beneficiaries whenever the request is filed before the Commission by a third party unless the absence of consent is duly justified

Consent cannot be obtained where the circumstances preclude it, as in the present case. The petitioners were not able to obtain the express consent of the potential beneficiaries, the patients, because of the petitioner's limited access to the Hospital, and the limited contact with the beneficiaries. During the visits DRI conducted, we were accompanied by Hospital staff at all times. There are also patients that due to their mental condition would require extensive support to provide consent.²⁹⁶ Considering both, the conditions that made it impossible for the petitioners to obtain this consent as well as the impossibility of the people institutionalized to file a complaint or to have this effectively addressed, the lack of express consent from the potential beneficiaries to present this petition on their behalf is duly justified.

C. The precedents of the Inter-American Court and the IACHR support the awarding of precautionary measures in the instant case.

The Inter-American Court and Commission have deemed it appropriate to award provisional and precautionary measures in similar situations to the present case. In this regard, taking into account the situation of the institutionalization of the 334 patients, as well as the fact that they are formally considered "persons deprived of their liberty,"²⁹⁷ the analysis of these measures was

²⁹⁵ See, e.g. CRPD articles 13 and 16.

²⁹⁶ Under the CRPD article 12, all persons with disabilities have the right to enjoy legal capacity. Due to their disability, they may require support in order to provide consent. In the context of an abusive institution where an individual does not have trusted family or friends to assist in decision-making, supported decision-making is nearly impossible.

²⁹⁷ According to various international instruments, persons with mental disabilities in institutions deserve the same protection as other people deprived of their liberty. In this regard this Commission has established that the deprivation of liberty can occur in various contexts –including the context of people interned in psychiatric institutions– and specifically the Commission stated that, "the obligations of respect and guarantee that States are charged with transcend the merely penitentiary or police detention contexts." Inter-American Commission of Human Rights, *Report on the human rights of people deprived of their liberty in the Americas*, OEA/Ser.L/V/II. Doc. 64, December 31 2011, para. 38. See also various international instruments which establish a wide concept of deprivation of liberty such as the Optional Protocol of the Convention Against Torture

conducted in consideration of the established standards of protection of that population group. This analysis can be found in Annex XX.

IV. CONCLUSION

Given the gravity and urgency of the situation, and the necessity to avoid imminent and irreparable harm to all 334 minors and adults detained at the Federico Mora Hospital, we request that the honorable Commission immediately adopt precautionary measures in accordance with article 25.5 of its rules of procedure.

V. PETITIONS

Considering the gravity and the on-going nature of the referred facts which threaten the lives and personal integrity patients of the Federico Mora, as well as the previous protective measures awarded by this Commission and the Inter-American Court (see Annex XXX), we request that the Commission require the Guatemalan State to immediately undertake the following measures:

- Adopt any and all immediate steps necessary to protect the lives and personal integrity of all people now detained at Federico Mora;
- Provide immediate medical attention, adequate food and clean water to the potential beneficiaries;
- Recognize that Federico Mora is an inherently dangerous facility that is not appropriate for psychiatric care or support for persons with disabilities; as such, the State should stop any new placements in the hospital, particularly people in need of acute psychiatric treatment. People in need of acute psychiatric care should be cared for in general hospitals or other outpatient crisis or community support centers. If such facilities or capacities at general hospitals do not exist, the State should oversee implementation of alternatives;
- End the use of isolation cells for people with disabilities at Federico Mora;

and other Cruel Inhuman or Degrading Treatment or Punishment (OP-CAT) which considers deprivation of liberty as “any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority,” and the article 14 (2) of the CRPD, that determines that “[...] If persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.” [...] . See also European Court of Human Rights, *Stanev v. Bulgaria*, judgment of January 17, 2012, paras. 117-118.

- Immediate plans should be made for the transfer of patients to other safe locations in the community where they can receive the care, support, and safe living conditions they need;
- Children (minors under age 18) should be given first priority for return to their families or other community placement with extended family or substitute families; women should be the next priority for out-placement.
- Plans should be made for the eventual closure of Federico Mora hospital or for its conversion to use exclusively as a prison; civilly committed patients should be separated from forensic detainees;
- Demand that the State investigate the facts which require the adoption of protective measures in the instant case, and identify those responsible for those facts, and impose the necessary sanctions, both administrative and disciplinary.
- Adopt these measures in consultation with the potential beneficiaries and their representatives, including organizations made up of persons with disabilities;
- Provide free, ongoing, and unlimited access to the facility to the petitioner human rights organizations, the Human Rights Ombudsman of Guatemala, disability rights organizations, and international technical assistance agencies such as the Pan American Health Organization (PAHO) and the UN High Commissioner on Human Rights (UNHCHR), to further evaluate the human rights and medical needs of people detained at Federico Mora and to make recommendations for needed reforms.
- Require the Guatemalan State to periodically report on the actions taken to fulfill these measures.