Visit to Mental Hospital, Varanasi and follow up of the review conducted earlier in July, 2007 by Dr. Lakshmidhar Mishra, IAS (Retd.), Special Rapporteur, NHRC on 5.7.2010.

I had accompanied and assisted in July, 2007 Justice Shri Y. Bhaskar Rao, former Member of the Commission in conducting a review of the activities/performance of Mental Hospital, Varanasi. Placed below is a tabular statement which indicates on the left side the observations, suggestions and recommendations made at the time of the said visit and on the right side the extent of implementation of these suggestions and recommendations/current status:-

S.No.	A gist of the observations/ suggestions and recommendations made at the time of the visit in July, 07.	Current Status as reported by the hospital authorities
1.	Physical infrastructure – This is a 200 year old hospital which has a total land area of 26.91 acres of which barely 50% has been utilized. – The structures were raised 200 years ago with lime and mortar without any DPC. The safety of the structures could be ascertained by making a reference to NBRI, Roorkie. – The roofing has been done by tiling. Such tiles need replacement from time to time;	Flow of funds for repair and maintenance continues to be adhoc, erratic and inadequate. However, after many years of waiting the following new structures have been taken up and have either been completed or in progress. – Construction of sheds to provide a waiting hall for OPD patients visiting the hospital with family members/relatives has been completed. The shed with asbestos sheet is open on both sides, not very comfortable particularly in summer months but is able to accommodate about 50 patients with family members/relatives.

	– No ceiling fans have been provided; – Heat and humidity of summer months make life of the inmates unbearable. – Lighting and ventilation are inadequate; – Repair of locking arrangement, repair of drainage and sewerage lines and drinking water pipes need constant attention; – Wood work is outdated and have developed cracks at many points; – The whole approach to repair and maintenance of the structures as of now is adhoc, piece meal and unscientific; – Allocations against estimates which are received for repair and maintenance are grossly inadequate. Estimates take long time for approval and when approval is communicated it is a reduced allocation;	– Construction of new OPD building and 30 bedded family ward is under progress. This is likely to be completed in 3 months' time. – Construction of road in OPD and male IPD almost completed. – Construction of separate boundary wall between IPD (female) and new OPD and Family Ward completed. – Construction of 50 bedded Male Ward and modular kitchen is likely to begin in a few weeks as reported by the construction agency. **<u>Comments of the Special Rapporteur:</u>** • It is encouraging to note that there has been a flurry of building and construction activities since our last visit. This will undoubtedly fill in the gap between what was needed and what was in existence. With a view to critically overseeing the quality of work of the new OPD Block and 30 bedded Family Ward I paid a visit to the worksite which is within the hospital premises and at a distance of few yards away from

	– It may be desirable to have all the repair estimates prepared in one go, get the administrative approval/ technical sanction in one go and get the repairs carried out sufficiently in advance of the rainy season.	the Superintendent's Office room. The work has been entrusted to Processing and Construction Cooperative Federation Ltd. which is an agency of the State Government. The said agency was selected on the recommendation of a Committee which was constituted specifically on the suggestion of Dr. (Mrs.) Jagdish Kaur, CMO (Medical Service), Office of DGHS, New Delhi. The works under execution in the new OPD Block and 30 bedded family ward were measured and were found to be of the following dimension:- – MO's room (7) – 4 metre x 3.6 metre with attached toilet; – Hall for waiting patients/ relatives – 7.6 metre x 4 metre with 6 attached toilets. Can accommodate 50 patients; – Verandahs (4) – 3.5 metre (wide) x 14 metre long can accommodate 50 patients. • Courtyard measuring 13.45 metre x 15.15 metre. It is meant to be a garden to be developed in consultation with U.P. Horticulture Department.

		• Pathological Laboratory measuring 4 metre x 7.2 metre with platform and provision for wash basin. The DGHS has been moved for sanction of the post of a pathologist and Laboratory Assistant to make the laboratory fully functional. • ECT room measuring 4 metre x 5.6 metre. To be a self contained unit an ECT room must have a recovery room. No thought/ attention has been paid to this genuine need. A recovery room with atleast 10 beds and fully airconditioned will have to be carved out of the present space or an extension will have to be built. • X-ray room measuring 4.2 metre x 4 metre. This includes a dark room measuring 1.8 metre x 1.94 metre and a technician's room measuring 1.94 metre x 1.8 metre. • Drug dispensing unit measuring 4 metre x 3.6 metre with an attached store room measuring 2.5 metre x 3.2 metre. • Registration room measuring 4 metre x 3.6 metre.

		While what is being provided now is an improvement over what existed earlier there are certain things wanting which constitute an irreducible barest minimum for physical infrastructure of a standard mental health hospital such as:- – Recovery room; – Central store room for storing medicines; – Central store room for storing foodgrains, vegetables, fruits etc.; – Central Record Room; – Room for Clinical Psychologist; – Room for Psychiatric Social Worker; – Seminar Room for inter departmental consultations; – Conference hall; – Library; – Geriatric Ward; – Child Guidance Clinic. It is necessary and desirable that these basic components of physical infrastructure be planned in advance, estimates of cost prepared and got approved by

		Government and construction work taken up in a phased manner depending on allocation of funds. While the total estimated cost of the new OPD Block and 30 bedded open/family ward is of the order of Rs. 2.29 Crores a sum of Rs. 3 Crores have already been placed at the disposal of the executing agency which is very much on the high side. It was explained that the excess of Rs. 70 lakhs is meant for construction of a 50 bedded male ward for the hospital which is estimated to cost Rs. 88.93 lakhs the break up of which is as under:- 1. Civil work – Rs. 69.35 lakh; 2. cost of internal and external water supply and sanitation – Rs. 6.93 lakhs; 3. cost for internal electrification – Rs. 6.93 lakhs. The deadline for the completion and handing over physical possession of the structures is as under:- OPD – December, 2010 Family Ward – December, 2010; IPD (male ward) – January, 2011

		At the time of my visit to the worksite the JE – Shri D.K. Pal was not found present. This is a crucial lapse at a time when the roof slab of the structure was being cast. The brick work appeared to be substandard. The bricks were substandard and so was the joinery work. The pointing of bricks was not being done properly. This was brought to the notice of the Asstt. Engineer – Shri N. K. Sharma. He was also asked to ensure (a) that the ratio of cement, sand and chips should be 1:1:5:2 (b) curing of the structure where roof slab was being cast is done at least for a period of 21 days in the minimum.
2.	**<u>Administrative infrastructure - a gist of observations and recommendations made:</u>**	**<u>Current Status as reported by the hospital authorities</u>**
	• A large number of posts in various categories were found at the time of last review vacant. • It was observed that in the ratio of 1 MO for every 25 patients a minimum number of 13 MOs should have been sanctioned for indoor patients and 4 MOs for OPD patients.	• As against a total number of 109 sanctioned posts, 95 have been filled up leaving 14 vacant posts. It can be said that the position has slightly improved compared to last review in July, 2007. • The number of psychiatrists sanctioned continues to be 6 against which 4 have been filled up (2 Psychiatrists +2 MOs) leaving 2 vacant posts. The position is highly unsatisfactory.

	• The actual sanction is less than 50% of this number while the number of MOs (including the Director) in position is only 3 or 25% of the requirement. • The norm laid down for sanction of staff nurse is 1 staff nurse for every 10 patients. Following this norm, a minimum of 33 staff nurses should have been sanctioned. • Fifty posts of attendants are in position but attendants cannot be substitutes of staff nurses. • In the same ratio i.e. 1:10, a minimum of 30 sweepers and sweepresses should have been in position for ensuring cleanliness in the outer surrounding and inside of the hospital (both OPD, IPD and all other areas). As against this only 14 posts have been sanctioned while only 12 are in position. • Dr. (Mrs.) Nalini Gaur who has assumed charge as Director on 10.7.07 is a	• An order posting 33 nurses has been issued in May, 2010. The letter also includes sanction of 11 attenders. However, the Director does not have powers to recruit them. • As against 50 sanctioned posts of attendants 47 are in position leaving 3 vacant. • Of 14 sanctioned posts of sweepers 13 have been filled up and one is vacant. • Dr. V.K. Srivastav has joined as Director in level 5 on 3.7.10. Before joining as Director he was Chief Medical Superintendent, Lal Bahadur Shastri Hospital for 3½ years. He is a chest-cum-TB Specialist who will retire on 31.7.10. • Dr. Amarendra Kumar's orders of transfer were cancelled after NHRC's intervention at the time of last review. He continues in his present position as Sr. Psychiatrist. • Dr. Pawan Kumar, Senior Psychiatrist has joined in place of Dr. R.P. Pandey. Dr. Satyendra Prakash and Dr. V.P.

	gynaecologist by discipline and does not have any prior experience of working in a psychiatric hospital. • Dr. Amarendra Kumar, Senior Psychiatrist has received his orders of transfer to the District Headquarters Hospital, Varanasi without posting of a substitute. • There is no Managing Committee to oversee the day to day management of the hospital; there are no small Sub Committees for different areas of work either. • There is no arrangement for sending the faculty and staff members for orientation and training. There is no Institute of Public Health in U.P. like the Institute of Public Health, Maharashtra at Nagpur for imparting such training. • A calendar of training programme should be drawn up and training imparted with the help of resource persons drawn from different sources both within and outside	Shukla have joined as GDMO 6 months and 2 months back respectively. • The position regarding MC remains unchanged. There is no MC; there are no small working Committees to look after various areas of interest. • There is no change as far as orientation and training of faculty and staff are concerned. • No separate orders have been issued by the State Government delegating administrative and financial powers to the Director. • The Director should seek permission of DGHS to (a) issue an advertisement inviting applications for staff nurses (b) conduct interviews and (c) make the final selection. Such a letter has already been sent on 22.5.10 followed by a reminder but there is no response. • Posts of Administrative Officer and Finance/ Accounts Officer have not yet been sanctioned even though the annual budget of the hospital is Rs. 3,39,71,129/-. To manage a

	Varanasi.	budget of this size there is only one Senior Accountant and OS (non-gazetted). The OS has joined recently and is going to retire at the end of July, 2010. There is one sanctioned post of Assistant and one post of LDC but both are lying vacant. The Director is not competent to fill up these posts. The DGHS alone can fill them up on a reference to be received from the Director. These powers should be delegated to the Director. • Of the 8 sanctioned posts of Pharmacists 7 are in position (3 Pharmacists and 4 Chief Pharmacists). They have not been sent for training anywhere. • One post of Prabhari Adhikari Pharmacist is still lying vacant. This is to be filled up on promotion from the existing incumbents of Chief Pharmacists. The DGHS should consider delegating this power to the Director so that the post can be filled up. • On the recommendation of NHRC the hospital authorities had moved the State

		Government as early as 31.5.2007 for sanction of the following posts:- – Anaesthetist – 1 – Pathologist – 1 – Lab technician – 1 – X-ray technician – 1 – EEG technician – 1 – Record keeper – 1 No decision conveying sanction of these posts has yet been communicated. Similarly the hospital authorities had on the same date requested the State Government for sanction of certain posts on outsourced basis such as:- – Washerman – 3 – Barber – 1 – Driver – 3 – Cook – 7 – Sweepers – 17 – Tubewell operator – 1 – Electrician – 1 – Data entry operator – 1 – Gate keeper – 6 – Peon – 2 – Mali – 2 – Plumber – 1

		While prima facie there is no serious objection to outsourcing such a large number of posts, it is important to bear in mind the issue of productivity, discipline and accountability which to some extent can be ensured by the following:- – Are these contractual employees punctual in their attendance?; – Do they have an I card to enter the hospital premises? – Do they have a job card listing out their duties and responsibilities? – Who oversees their attendance, their volume and quality of work? – Who is responsible for ensuring that they are disciplined? – Who is responsible for disbursement of their wages? – Who from the side of the hospital management remains present at the time of such disbursement?

– Is there a mechanism through which they can ventilate their grievances?

However, no sanction of these posts on outsourced basis has yet been communicated by Government.

According to the norms notified under the Mental Health Act, 1987 in Government of India Gazette 31.5.2007, the following is the barest minimum staff requirement for Mental Health Hospital, Varanasi:-

S. No.	Name of the post	Norms	No. of posts required
1.	GDMO	1:50	Male – 4 Female – 2 Total – 6
2.	Clinical Psychologist	1:100	3
3.	Occupational Therapist	1:100	3
4.	Psychiatric Social Workers	1:100	3
5.	Staff Nurse	1:10	33
6.	Attendants	1:5	Male – 7 Female – 4
		Total	**59**

While sanction for clinical psychologist, psychiatric social workers and occupational therapist has been received, sanction for 6 posts of GDMOs is yet to be received. Sanction for 33 posts of staff nurses have been received but with a rider that (a) they will be in a consolidated wage of Rs.

		15,000/- per month and (b) the post will have to be filled up through an NGO which appears to be a difficult proposition.

OPD:

3.	**Observations made at the time of review in July, 2007:** • The average daily outturn of patients at the OPD ranges between 80 to 90. • There is no proper sitting accommodation for them. • There is no proper arrangement for supply of potable water or toilets for them as also for the relatives accompanying them. • The patients travel long distances by bus or train at considerable expense and inconvenience.	• Average turn out of mentally ill patients at the OPD has gone up to an average 120 signifying increase in incidence of mental illness in U.P. • A temporary shed has been constructed which can accommodate about 50 to 60 patients at a time. • A new OPD Block is under construction. • No data entry operator post has been sanctioned on a regular basis so far. There is, therefore, no proper arrangement for collecting, compiling and analyzing the following basic data pertaining to every patient:- – personal history; – family history; – history of illness; – demographic profiles.

Comments of the Special Rapporteur:

The following table would indicate that the attendance of patients at the OPD during the last 7 years has registered substantial increase

Years (Jan – Dec)	Male	Female	Total
2004	9092	6227	15,319
2005	10747	6832	17,579
2006	11,775	7380	19,155
2007	12,254	8654	20,908
2008	15,106	8027	23,133
2009	18,634	9211	27,845
2010 (upto 30.6. 10)	11,221	5714	16,935

Such increase in the number of patients attending OPD calls for planning of certain additional measures to be initiated to deal with the situation as under:-

– the sitting space for patients coming along with family members/relatives will have to be improved;

– facilities and amenities by way of access to potable water, conservancy facility, newspaper stand with local dailies and television for access to information and recreation will have to be provided;

– the number of registration counters will have to be

		increased; the number of people manning the counters will have to be correspondingly increased; – an observation room has to be set up for keeping patients who are violent/aggressive under sedation so that they can be examined in the OPD after they gain full consciousness and a state of complete tranquility is restored to them; – the Record Room and Drug Dispensing Rooms should preferably be located close to the OPD; • Since many OPD patients travel by train/bus over long distances and may not have eaten anything on the way (when they are travelling) it is normal and natural that they should be hungry when they arrive at the OPD. It is, therefore, necessary and desirable to set up a canteen facility so that OPD patients may have tea and snacks in the said canteen (this is necessary as the average waiting period in the OPD for a patient may range from 4 to 6 hours depending on the outturn of patients and number of MOs

		available to examine them and it will be cruel and inhuman to keep them waiting and hungry for such a long period); – It is quite possible that many patients coming from far off places will be arriving late when OPD hours will be over. It may be desirable to have 2 separate emergency rooms with atleast 10 beds each one for male and another for female patients who can stay here overnight and get themselves examined in the OPD on the following day. Such arrangements exist in many other mental health hospitals. • We need to go in for a liberal State Policy to enable the Director of the hospital to recommend deserving cases of poor and indigent patients (who are coming from far off places and who can ill afford the cost of travel either by bus or by rail) to the Road Transport Corporation Authorities as well as Railway Authorities so that they may get concessional ticket (which is affordable) to travel by bus or rail. Such a policy is in vogue in

		Jharkhand State and Superintendent/Director, RINPAS has been authorized by the State Government to recommend such deserving cases. In the absence of a State Policy it is understood that the recommendation made by the Director to the local transport or rail authorities is not being honoured by the latter. Therefore, the sooner a State Policy in this regard is adopted, the better it is for the interest of poor and indigent patients.
4.	**<u>Right to food: observations and recommendations made in the last review report (July, 2007):</u>** • The existing kitchen building being in a bad shape is currently under renovation. • Lighting and ventilation as also standards of cleanliness inside the building need improvement. • One sanctioned post of cook is lying vacant for the kitchen in the male block while there is no sanction for the female block at all.	**<u>Current Status:</u>** • The kitchen continues to be in a bad shape. The observations made 3 years ago hold good even now. • The post of cook is even now lying vacant. The Director has moved Government for sanction of 7 posts of cooks but no sanction received so far. No post of Kahar (helper) has also been sanctioned. • Tea is being served only in the morning; there is no afternoon tea.

	• No kahar (helper) has been sanctioned for either of the kitchens. The day to day cooking work is being managed by male and female attendants. • There are 2 sets of timings i.e. one from November to February and another from March to October. In both the timings dinner is being served at 4 PM and 5 PM which is too early. Besides, it leaves a gap of 9 to 10 hours between dinner and breakfast which is likely to give rise to gastric problems. • There is no provision for serving any afternoon tea and snack. • In the absence of trolley service food is being transported manually from the kitchen to the barracks. • In the absence of dining table, inmates are required to take food on the floor. • Since March, 2007 the FCI has discontinued supply of rice and wheat on the	• There are no changes in timings for serving food. • In the absence of dining table food continues to be served on the floor. • No trolley has been procured as yet; food after being cooked continues to be transported from the kitchen to the barracks manually. • Despite the assurance given by DM to make supplies of rice and wheat available from PDS no action was taken and these items continue to be procured from the open market at high rates. • The scale of allocation under food has been revised from Rs. 20/- to Rs. 35/-. Supplies of food grains are taking place through a government approved contractor. **<u>Comments of the Special Rapporteur:</u>** A good quality food management involves the following:- – Procurement of food grains of standard quality;

	strength of permit and, therefore, these 2 items are being procured from open market at higher rates. The matter was brought to the notice of DM Varanasi and she had assured to take up the matter with FCI for restoration of the supplies as before. • The nutritive value of food comes to 2500 kilo calories which is inadequate. It should be 3000 – 3500 kilo calories for male and 2500 – 3000 kilo calories for female patients. • The scale of expenditure is Rs. 20/- per patient (subsidized) and Rs. 70/- (non-subsidized). This is low and does not meet the full cost of diet.	– Scientific storage of food grains, fruits, eggs, vegetables in a clean room, well lighted and ventilated, preferably on clean platforms and not on the floor; – Prescribing a scale of diet which is consistent with cost of food articles and conforming to the special status of patients (TB, jaundice – hepatitis, gastroenteritis, low weight, low haemoglobin count etc.); – Preparation of food in the kitchen in an environment of total hygiene and cleanliness, free from dust, fume, pest etc.; – Food is neither to be over cooked or under cooked; – Storing food hot in stainless steel containers; – Serving food on a dining table in a room which is airy and well lighted with a human touch and not in the open; – Ensuring personal hygiene of all patients (through cleaning of their hands and feet) before they settle down to their meal;

		– assisting physically and orthopaedically handicapped patients, patients who are victims of rheumatoid arthritis, whose connective tissues have been damaged, who have debilitated fingers, whose reflex action is zero and, therefore, who are incapable of taking food entirely on their own; this will also ensure prevention of wastage of food; – playing soft and subdued music through a music channel so that a joyous environment is created where the patients can take their food with freedom and spontaneity; – making the hospital self sufficient by developing an agricultural farm/kitchen garden, to the extent there is agricultural land within the hospital premises, making the patients who are comparatively strong and skilled to work in the farm to raise vegetables, food grain crops, fruits and vegetables etc. (which will promote dignity of labour) on RINPAS Ranchi model;

		– all the cooks must be medically examined once every quarter; – all of them must be provided with aprons; – a dietician from within or outside the hospital must certify the nutritive value of food. Keeping the modular kitchen, Agra which has been built and made operational on the suggestion of the Special Rapporteur of NHRC, Mental Health Hospital should formulate a proposal to construct a modular kitchen with the following components, work out the financial implications and send the proposal to State Government:- – a modern chimney regardless of the type of fuel used; – sufficient number of exhaust fans; – flyproof wiremesh all around; – flyproof automatic closing doors; – floors made of an impermeable material; – a platform for washing vegetables daily with potash permanganate and for cutting before cooking;

		– an electric kneader for preparing a paste out of atta prior to making chapattis; – chapatti making machines, mixers and grinders; – adequate number of taps inside the kitchen; – LPG, hotplate and micro oven; – Cooking and serving utensils to be made of stainless steel. A modular kitchen may comprise of the following:- – waiting lobby with a platform towards left and dispensing space for food on the night – 11 metre; – vegetable storage platforms – 12 metre; – preparation of food area – 20 metre; – cooking area – 120 metre; – washing area – 20 metre; – food storage area – 30 metre; – pantry area – 16 metre; – verandah – 12 metre;

		– room for changing aprons – 10 metre; – entrance – 10 metre; – toilet block – 10 metre; – gas bank – 10 metre; • The ideal food timings should be: - – bed tea - 7 AM; – break fast – 7.30 AM to 8 AM; – lunch – 12 Noon to 1 PM; – after tea (with snacks) – 4 PM; – dinner – 7 PM.
5.	**<u>Right to Water:</u>** **<u>Observations and recommendations</u>**	**<u>Current Status</u>**
	• Currently water is being supplied from a tube well through pipes to different barracks. It is being bleached and stored for use in a storage tank with a capacity of 5000 litres. • Storage capacity may be adequate but water cannot be said to be potable. • Sample of water being supplied at present has	No change has taken place since the last review on July, 2007. **<u>Comments of the Special Rapporteur:</u>** • Right to water, according to the apex Court is as fundamental a right as right to food, both being integral part of right to life (Art. 21). • Water is required for absorption of food as also for cleaning, washing, gardening, bathing,

	never been sent to an approved PH laboratory.	cooking, flushing the toilet etc. • Approximately, 130 litres of water per head would be needed for all these purposes. – At the current bed occupancy rate (175) about 22,925 litres of water would be needed per day for about 175 patients. The overhead tank with 50,000 litres capacity which is being filled thrice daily is, therefore, more than adequate but we need an arrangement for filtration. We also need to draw samples of water once in very 6 months and send the sample to an approved PH laboratory for test and certification that (a) water is free from chemical and bacteriological impurities and (b) it is free from excess of iron, sodium, calcium, magnesium and floride; – The overhead tank is required to be cleaned regularly with the state-of-the-art technology with mechanized dewatering sludge removal, high pressure cleaning, vacuum cleaning, anti bacterial spray.

6.	**Right to Environmental Sanitation:** **Observations and recommendations:**	**Current Status**
	• There are in all 27 toilets for 269 patients (as on 16.7.07) which works out to a ratio of 1:10 as against the ideal ratio of 1:6 as recommended by Prof. Channabasavanna Committee. • The toilets are, however, old and there being no cisterns are being manually flushed by buckets of water. • Availability of water for use in manual flushing is adequate.	• The number of toilets have been increased to 35. • Cisterns have been fixed to the new toilets. • The patient toilet ratio works out to 5:1 which is sufficient and more than what is desirable. **Comments of the Special Rapporteur** • While it is encouraging that both the number of toilets and patient toilet ratio has improved, the following deficiencies continue to be areas of concern:- I. All the toilets are Indian commodes. We need a few WCs for use by old and infirm patients, victims of rheumatoid arthritis whose connective tissues would have been damaged and for whom it is medically inadvisable to squat on an Indian Commode. We should, therefore, go in for atleast 2 to 3 WCs by way of conversion.

		II. We need to instal cisterns in all the toilets as manual flushing will not ensure the desired level of environmental sanitation. It may lead to communicable diseases. Besides, for old and infirm patients it is difficult to carry buckets of water for manual flushing. III. Since this is a 200 year old hospital it is not known if sewer lines have been scientifically laid in the beginning, there are only soakpits, whether the hospital sewer has been connected to the main sewer of Varanasi city, whether they have been inspected and whether they need replacement. The hospital authorities need to consult the Public Health Engineering Department to get this inspected. IV. Toilets need to be cleaned daily to keep them dry and tidy. Since there are only 13 sweepers and 27 toilets this may appear to be difficult unless the number of sweepers is engaged.

7.	**Management of personal hygiene Observation and recommendation:**	**Current Status**
	• Laundry service is being provided by a single washerman manually. • For a hospital with 331 sanctioned bed strength this is considered inadequate. • A mechanized laundry service should be introduced at the earliest.	• There is no change in the manual laundry service. • There is a single washerman who is fairly old and therefore, is not able to cope with the workload. • There is delay in delivery of clothings. • The DGHS has been moved for sanction of 3 washermen but there is no response. **Comments of the Special Rapporteur:** A mechanized laundry is a composite unit which comprises of (a) one washing tumbler (b) one drier and (c) one iron for pressing. Three workers in the minimum would be needed and this i.e. the automatic unit with the requisite manpower should be sanctioned without further delay in the larger interest of personal hygiene of all inmates. Personal hygiene of all inmates in its totality starts in the kitchen and goes to the wards, dining table, OT,

		toilet, library and assembly places and should take care of the following:- – at the kitchen cooks should be provided with 2 sets of aprons, cap and nasal mask; – there should be provision for supply of hot water in the kitchen; – utensils should be thoroughly cleaned with detergents in each shift after cooking; – laundry services are mechanized as manual laundering leads to accumulation of water and an unclean and unhygienic environment; – clothings are collected every day at 8 AM; – they are cleaned, pressed and delivered at 5 PM; – the bed sheets and pillow covers are changed every alternate day; – there is a female barber to ensure personal hygiene of female mentally ill persons;

		– adequate quantity of soap, detergents etc. to the inmates should be issued to wash their clothings manually during the interregnum i.e. till mechanized laundry operation gets ready; – adequate quantity of oil and lifebuoy soap should be issued to the inmates to use them while taking bath and to keep them clean; – toilets should be thoroughly cleaned with detergents and chemicals to present a tidy and hygienic look.
8.	**<u>Uninterrupted supply of electricity Observation and recommendation</u>**	**<u>Current Status</u>**
	• As against the required load of 50 KW only 40 KW load has been sanctioned. • There is frequent interruption and tripping which hampers the quality of service in the hospital. • There is a diesel generator set but due to scarcity of fuel (diesel) the same is not functioning optimally.	• The DG set is now functional but load shedding is also acute. • The U.P. State Electricity Board has sanctioned a new transformer of 50 KVA capacity and it is hoped that within 2 to 3 weeks the installation will be completed. Once this is done, it will ensure stability and durability of power supply. **<u>Comments of the Special Rapporteur:</u>**

	• The power backup for the barracks is, therefore, provided by an inverter. • A separate transformer should be installed to ensure 24 hours uninterrupted supply of power. The matter should be taken up by State Health Deptt. with State Energy Deptt. and U.P. State Electricity Board.	• The hospital authorities must enter into an annual maintenance contract with the manufacturer of the DG set for its timely repair and maintenance. • The said AMC must be renewed year after year. • Adequate quantity of diesel as per requirement should be made available in time to keep the DG set going. • The power for purchase of diesel for this purpose should be delegated to the Director. • In view of sharp hike in cost of diesel, the contingency amount for this purpose should also be augmented. • In the event of breakdown of the DG set only an authorized professional vendor duly authorized by the manufacturing company should attend to the repair work and none else. • The installation work of the new transformer should be got executed under direct personal supervision of the Director.

9.	**Telephone Service** **Observation and recommendation** • There is only one telephone for the office of the Director and no PCO. • It was felt that installation of a public booth inside hospital premises will bring outsides which may not be desirable from the security point of view.	**Remarks of the Special Rapporteur** • Telephone is the primary means of communication or a window for establishing contact with the outside world. It is not only useful for day to day office work but is also of use for the relatives/family members of the patient to establish contact with the hospital authorities to know the condition of the patient. For this purpose the following arrangements need to be institutionalized:- – all calls coming from outside and in particular from the relatives/family members of a patient must be received properly; – the telephone number, name, relationship with the patient of the caller should be noted down; – a literate attender who is empathetic and sensitive may be made responsible for this purpose; – the message should be accurately recorded; – the message should be handed over to the MO in

		charge of the ward at that point of time; – information relating to the health/condition of the patient should be correctly elicited and passed on to the attender who had received the first call; – the information should be passed on to the called i.e. Relative/ family member of the patient. To make this possible, in addition to the lone telephone installed in Director's room, another telephone may be installed in the emergency room and should be made known to the relatives/ family members of the patient to facilitate them to make enquiries about the patient from time to time.
10.	**<u>Library-cum-reading room for patients:</u>** **<u>Observation and recommendation:</u>** • There is no library-cum-reading room for patients. • Newspapers and weekly magazines are kept with	• There is no change in the current status. **<u>Comments of the Special Rapporteur:</u>** • This is yet another grey area of Mental Health Hospital, Varanasi.

	attendants in the barracks. • The use of the same by the inmates is rather restricted.	• Amongst the inmates in the IPD there are individuals who are literate and numerate who would like to read books, journals and periodicals of their interest and relevance. • Since they live in a controlled environment, they will find it difficult to articulate their preferences and interests in this regard unless these are specifically ascertained. • The hospital authorities should ascertain their preferences and interests and document them. • On the basis of the preference and interest as expressed, hospital authorities should make available a reading room with chairs and reading tables, properly lighted and ventilated on the one hand and make available the books, journals, periodicals, newspapers on the other. • There may be a few good human resources among the patients who have recovered substantially, who are literate, skilled, creative and imaginative, are capable of recording feelings of others, effectively communicating to

		others as also capable of organizing activities which would bring happiness and joy to other patients. • Such resources should be identified and harnessed for creating a literate environment as also for instilling hope and faith in the minds of other patients who are unable to read and write and, therefore, unable to have a widow to the outside world through books, journals and periodicals. The hospital authorities could treat the experiment obtaining in GMA, Gwalior and implement the same in the larger interest of the patients.
11.	**<u>Cultural and recreational avenues</u>** **<u>Observation made in July, 2007:</u>** • The recreational avenues for the inmates include volley ball, carom and chess. • These avenues have to be consistent with lock up timings.	**<u>Comments of the Special Rapporteur:</u>** • There are 36 criminal elements and 139 non-criminal elements in the hospital. Lock up timing is relevant in a custodial environment but importance of social communication should not be lost sight of. There is considerable social isolation for both criminal and non-criminal elements on account of the following reasons:- – there is no park inside the hospital where inmates can

		sit with their relatives and relax in the evening hours; – all open spaces inside the hospital premises have been paved leaving no scope for their conversion into mini parks; – there is minimal greenery or sylvan setting in the hospital premises; – there is no open /family ward; – there is no library /reading room for the inmates; – there is no clinical psychologist who can make a beginning in counselling as an individual or group effort. Against the above backdrop of lack of social communication resulting in social isolation the following steps could be initiated:- – assess the levels of literacy and numeracy of the inmates through a survey; – take steps to make those who are totally unlettered

		functionally literate with the help of those inmates who are functionally literate, who are going to stay in IPD for a reasonably long period and who have the urge and inclination to teach; – open up avenues of dance, drama, music and cultural activities on important dates in a year and ensure participation of inmates who depending on the state of their body and mind are capable of participating in these activities (the hospital authorities could benefit by the experiment obtaining in IMHH, Agra with the initiative and leadership of Mrs. Kusum Ray, MO incharge of rehabilitation of inmates through participation in cultural programmes; – identifying individuals who have good communication skills who can make others feel at home by being informal and friendly,

		unconventional and unorthodox, who can engage others in good conversation and thereby enable them to open up; – accord public recognition to those who are endowed with creativity and histrionic talent.
12.	**<u>Yoga, Pranayam and meditation</u>** **<u>Observation:</u>**	**<u>Current Status:</u>**
	• No such avenue has yet been made available. • It may be worthwhile to engage a yoga teacher who will be able to initiate a number of inmates (both criminal and non-criminal) into this disciplining process.	Initiative was taken to invite volunteers from outside the hospital but in the absence of provision for payment of any honorarium the effort did not succeed. The example of GMA, Gwalior could be emulated in the larger interest of disciplining body, mind and spirits of inmates.
13.	**<u>Occupational Therapy</u>** **<u>Observation and recommendation</u>**	**<u>Current Status</u>**
	• The OT unit is an excuse for a full fledged and optimally performing unit. • Barely 35 patients are being trained annually in the 5 weaving looms.	• No new skills/trades have been introduced. • There is no increase in the number of patients participating in the activities in the OT unit.

	• No wages are being paid to the inmates contrary to the practice adopted elsewhere. • Required space being available for expanding the activities to introduce a number of new skills/trades such as file covers, envelopes, file boards, cartons (medicine boxes), candles, wooden toys, photo frame etc.	• Additional posts of Instructors have been sanctioned; these are yet to be filled. • There is nothing worthwhile to report on the activities in the OT Unit. **Comments of the Special Rapporteur:** The importance of OT Unit as a promoter of unity and solidarity, discipline and bonhomie concentration and creativity need not be over-estimated.
		Varanasi is an old historical city and well known for knitting, embroidery and zari work as also numerous art and craft forms. There are traditional artisan families who through their imagination and creativity have created objects which could be feasts for the eyes of humanity. There is no dearth of raw materials to bring out the finished products mentioned in column 1. It is regrettable that with all these advantages and despite space being available there has not been any worthwhile positive step taken either in the direction of expansion or diversification of the skills/trades being imparted. The same 5 weaving looms continue even today

		and no new trades/ skills have been added. To achieve a break through in the direction of expansion /diversification the following steps need to be initiated:- I. A survey should be undertaken amongst the inmates to ascertain the artisan background, if any, they come from, the skills/trades learnt by them already and whether there are any new skills/trades they would like to learn. II. A market survey should simultaneously be conducted to ascertain the names of the products concerning artisans which have maximum market potential. III. A project document on the basis of these 2 surveys needs to be formulated which would comprise of the following:- – New skills/trades which need to be introduced; – Names and number of the artisan inmates who would be involved in the project;

		– Requirements of raw materials; – Names of finished products; – Time span; – Cost; – Outlet for sale; – Payment of wage to MT and Ts.
14.	**<u>Modified ECT</u>** **<u>Observations:</u>**	**<u>Current Status</u>**
	• No modified ECT has been installed as yet. • A proposal to this effect has been sent and is still awaiting the approval of the State Government.	• This will be possible with completion of the new OPD Block. Simultaneous planning for a Recovery Room fully air conditioned should be made.
15.	**<u>Drug Deaddiction Ward</u>** **<u>Observations:</u>** • There is no deaddiction ward attached to the hospital. • Considering the increase in substance abuse and its likely impact on mental illness deaddiction ward is a prime necessity. • A proposal to have such a ward may be formulated and sent to Government of U.P.	**<u>Current Status</u>** • No proposal has yet been formulated and sent to Government. The current status remains unchanged. **<u>Comments of the Special Rapporteur</u>** Currently there is only one drug deaddiction ward under the Deptt. of Psychiatry in Banaras Hindu University. The Director may depute one of the staff members – preferably one Senior MO to go

		and study the set up in BHU, get the basic inputs on (a) physical space (b) tools and equipments and (c) manpower – both medical and para medical, work out the administrative and financial implications and formulated a self contained proposal. The said proposal may be sent to Government of India for funding through the State Government.
16.	**<u>Pathological investigations</u>** **<u>Observations:</u>**	**<u>Current Status</u>**
	• There is no pathological laboratory in the hospital. • All blood and urine profiles are being sent to Pandit Deendayal Upadhyay Hospital for investigation and report. • There is no x-ray machine even though a post of radiologist has been sanctioned. • It is desirable to have in place facilities such as x-ray, ultrasound, EEG, ECG, all blood and urine tests including serum lithium estimation.	• Proposals for creation of the post of an anaesthetist, pathologist, lab technician, x-ray technician, EEG and ECG technicians have been sent to DGHS and Deptt. of Medical Education. Sanctions are still awaited. **<u>Comments of the Special Rapporteur:</u>** Since the x-ray, ECG, EEG and modified ECT facilities are being created, the space as well as equipments which will be installed will be infructuous without having the requisite manpower in position. It is, therefore, urgent and imperative that the posts of technicians are sanctioned and

		recruitment process completed at the earliest to put the pace and equipments into optimum use.
17.	**<u>Special problems of long stay patients:</u>** **<u>Observations made in July, 2007:</u>**	**<u>Current Status</u>** • The Visitor's Board comprises of the following:- **<u>Official Members:</u>** District Judge – Chairman; District Magistrate – Member; Chief District Medical Officer – Member; Senior Superintendent, Central Jail – Member; Director, Mental Health Hospital – Member; **<u>Non-Official Members:</u>** Dr. S.M. Daud – Member; Smt. Mandavi Prasad Singh – Member; Shri Padmakar Choubey – Member; The meetings of the Board used to be held once in 6 months earlier but now they have been held once in 3 months. The table below indicates the meetings of the Board held in 2009 (Calendar Year), number of mentally ill persons who have been declared fit for discharged and number of mentally ill persons who have actually been discharged:-

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<table>
<tr><th>Date(s) of the meeting of the Board</th><th>Number of mentally ill persons declared fit to be discharged</th><th>Number of patients who have been actually discharged .</th></tr>
<tr><td>17.2.09</td><td>38</td><td>38</td></tr>
<tr><td>8.7.09</td><td>30</td><td>30</td></tr>
<tr><td>15.12.09</td><td>28</td><td>28</td></tr>
<tr><td>17.3.10</td><td>8</td><td>8</td></tr>
<tr><td>16.6.10</td><td>12</td><td>7</td></tr>
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• Long stay patients include 26 non-criminals and 18 criminals.

• Such long stay is attributed to limited number of meetings of the Board of Visitors headed by the District Judge.

• The Board meets only twice a year which is not enough to do justice to a large number of pending cases.

• The other reasons which could be attributed to long stay are:-
– some homeless/destitutes have been ordered admission by Magistrates long time back and they are still continuing in the hospital;

– some patients have been admitted (mostly by obtaining order from Magistrates) by relatives and
</td>
<td>
• Long stay patients can be divided into 2 categories namely – those who at the time of admission were chronically ill, had associated complications along with mental illness (appendicitis, cardio vascular complications, respiratory complications etc.), who have not recovered till date and who will take long time to recover;

• Those who have substantially recovered, who have been found to be medically fit for discharge but whose ancestral home/native place/whereabouts are not known and who, therefore, cannot be discharged.

The current status of such patients is as under:-
I. Non criminal long stay patients – 17 male;
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	family members giving false address in admission paper; – even after a patient has been examined by the psychiatrist and has been declared medically fit for discharge, there is delay in arrangement of police escort by concerned jails for transfer of such parties.	II. Criminal long stay patients – 3 male over 1 female 10 years • Address with photograph of the patients being documented. • Telephone numbers are being kept wherever the same are available. • Communications are being repeatedly sent in the address available with the hospital authorities to relatives/ family members requesting them to come and take charge of patients at the time of discharge. **Comments of the Special Rapporteur:** • It is encouraging that the Board of Visitors once in 3 months, declaring a number of persons medically fit for discharge and that the advice/recommendation of the Board is being acted upon. • Regarding delay in arrangement in police escort, the matter should be taken up with DG of Police by the hospital authorities.

<table>
<tr><td>18.</td><td><u>Death Audit</u>

<u>Observations made in July, 2007</u></td><td><u>Current Status</u>

<u>Views of the Special Rapporteur:</u></td></tr>
<tr><td></td><td>Yearwise breakup of death cases between 2003 and 2010 (till 30.6.10) is as under:-
<table><tr><th>Year</th><th>Criminal</th><th>Non criminal</th><th>Total</th></tr><tr><td>2003</td><td>4</td><td>4</td><td>8</td></tr><tr><td>2004</td><td>10</td><td>7</td><td>17</td></tr><tr><td>2005</td><td>6</td><td>6</td><td>12</td></tr><tr><td>2006</td><td>3</td><td>3</td><td>6</td></tr><tr><td>2007</td><td>3</td><td>3</td><td>6</td></tr><tr><td>2008</td><td>1</td><td>1</td><td>2</td></tr><tr><td>2009</td><td>0</td><td>1</td><td>1</td></tr><tr><td>2010</td><td>1</td><td>2</td><td>3</td></tr><tr><td>Total</td><td>28</td><td>27</td><td>55</td></tr></table>
These deaths have taken place not in the mental hospital but in the following Government hospitals where the cases were referred for specialized treatment such as:-
– Pandit Deendayal Upadhyay Government Hospital, Varanasi;
– SSPG District Hospital, Varanasi;
– Specialized Hospital, BHU.</td><td>• It is necessary and desirable to have a correct scientific understanding of the causes of such deaths before we proceed further.
• To illustrate, cardio respiratory failure is a mode and not a cause of death.
• Similarly psychosis cannot be a cause of death alone.
• There are certain biological factors/ indicators which are associated with Schizophrenia which could cause death, not Schizophrenia perse such as:-
– to illustrate, cardio-respiratory failure is a mode and not a cause of death.
– Similarly psychosis cannot be a cause of death alone;
– There are certain biological factors/ indicators which are associated with Schizophrenia which could cause death, not Schizophrenia perse such as:-</td></tr>
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	• In all these cases, the post mortem reports have been received in the format prescribed by NHRC which is a detailed one. • There is, however, no such format for a detailed report from the treating physician in the hospital where the death took place. • In case of convicts or UTPs the cause of death is investigated by a Magistrate. If the convict or the UTP has come from another district the Magistrate of that district undertakes the responsibility for conducting such investigation. • The investigating Magistrate does not come to Varanasi where the death has taken place but summons the medical officer of the mental hospital who referred the case for specialized treatment or the treating physician of the hospital where the patient was treated or both and conducts the investigation at a place which is far away from the place of occurrence.	– Schizophrenic patients cannot sneeze; – While eating there is a possibility that they may be choked to death as the vegal nerves of the suffering Schizophrenic patient have been weakened. – Similarly, mania with psychotic symptoms cannot be a cause of death. • In all such cases which are referred by the mental hospital to another hospital for specialized treatment a close liaison and coordination should be maintained on the status of health of the patient whose case has been referred and the physician in charge of treatment of the patient at the referral hospital should keep the MO of the mental hospital posted with latest developments relating to the patient. • All possible efforts should be made to save the life of the patient.

	• The hospital is already having acute shortage in the cadre of psychiatrists/ MOs. The problem on account of such shortage gets aggravated when a MO is summoned and remain away for days together. It causes severe dislocation in the functioning of the hospital.	• If, however, despite best efforts the life could not be saved, the cause of death should be accurately recorded. • The report specifying the cause of death should be submitted to the Chief Medical Officer of the Government Hospital for scrutiny and acceptance. • As far as investigation into the causes of death of a convict or UTP is concerned, the Magistrate conducting such investigation should come over to the place where death took place instead of summoning the MO of the mental health hospital to go attend the inquiry at the place of posting of the Magistrate. NHRC needs to bring this to the notice of High Court concerned so that uniform instructions can be issued by the High Court of the State to all subordinate Courts.
19.	**<u>Miscellaneous Observations and recommendations:</u>**	
	• There is a 150 year old Central Jail where overcrowding seems to be the dominant note (against a sanctioned strength of 90s the occupancy is 2300	

	prisoners). • Of them 51 are mentally ill who are also life convicts. • Most of them constitute a serious threat to the health, safety and well being of other inmates. • The Psychiatrist of the mental hospital is going to the Central Jail to examine these mentally ill persons once in 3 months. • The correct arrangement would be to (a) allow them to be shifted to mental hospital (b) subject them to close supervision and attention (c) increase the manpower in the mental hospital to handle this added responsibility and (d) create a climate for good conduct, medical fitness and acceptability by the family members so that the pace of release of these life convicts who are also mentally ill can be hastened and the processes of their reintegration into the mainstream of the society can be facilitated.	

20.	In a mental health hospital one has to deal with an abnormal category of human beings who do not know what they do not know. They require round the clock vigilance and surveillance and special care and attention. For this it is desirable that most of the MOs and para medical staff stay within the premises of the hospital. This in the current situation is not possible as compared to the number of officers and staff members being 100+ there are only 28 staff quarters. A phased programme for construction of additional staff quarters should be taken up keeping this perspective in view.	
21.	The hospital being old requires constant vigilance so that timely repair can be undertaken and untoward incidents like collapse of structures can be preempted.	
22.	Considerations of safety and security should be balanced with those of comfort and convenience, tidiness and feel good factor.	
23.	Director, Sr. Psychiatrist and MOs must be provided with separate rooms with attached toilets which do not exist at present.	

24.	Library is the gateway to knowledge and information. It is needed for the Director, Sr. Psychiatrist and MOs so that they can keep themselves abreast of the latest changes and developments in Psychiatry. It is also needed for the patients for their knowledge, information, recreation and utilization of their spare time. Two such libraries will have to be simultaneously planned and properly equipped.	
25.	Whether it is a new construction work or repair and maintenance work quality should be the hall mark. This is not the case with mental hospital, Varanasi. Drive ways have been paved but due to poor quality of execution they have developed cracks. There are a number of blocks which are beyond repair and need to be demolished but they are not being demolished. New blocks are being constructed but the quality of work was found to be sloppy and supervision poor (JE remaining away when the roof slab is being cast leaving the contractor to rule the roost). There does not appear to be any sense of urgency and seriousness of concern in the management of the hospital.	

A bizarre incident occurred as I was preparing to leave around 12 Noon on 5.7.10. An elderly couple in their 60s came and started crying inconsolably before me and when asked as to what was the cause of their grief they said there was one and only one cause i.e. their son (Nagendra Kumar Dubey @ Sonu). He was in the prime of his youth when he became a victim of bipolar affective disorder. He was aggressive and violent and was beyond control. He started demolishing everything. He physically assaulted his parents, brothers and sisters. He was a reign of terror for the household. On account of his ailment it was the beginning of a process of total ruination of the household. With great difficulty they managed to bring him here and got him admitted. Their only prayer before me was 'Please keep him in the hospital as long as you can. Please do not send him back home. For if he returns to the household that will be the end of the household'.

Having heard their story with patience I decided to go and instantly meet the patient in the closed ward. When I reached the ward he was sleeping perhaps under the effect of sedation as no body sleeps around 12 Noon.

On my request the inmates woke him up. He came and stood before me, dazed and expression less. I then told him 'There is none in this world as venerable as your parents. They have brought you to this world, they have raised you and given you a good upbringing. Today you are healthy and strong and vibrant with manliness on account of their struggle and sacrifice. You would not have been what you are without them. You cannot repay even one millionth part of what you owe to them in this life or after. The least that you can do is to treat them with kindness and compassion as they are old and are in need of your care. Tomorrow when you grow old you will be in a similar need and if you treat your parents the way you are treating, your progeny will treat your likewise'. He heard me with rapt attention. There was not a murmur in his lips and he quietly went back to his bed. To the Director and MOs who had accompanied me I requested them to monitor the pace and progress of recovery and keep the parents informed while cheering them up all the while that the boy was in their care and control.

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