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Date: 14/05/2025

DH-DD(2025)558

Meeting: 1531st meeting (June 2025) (DH)

Communication from an NGO (Centre for Legal Resources) (02/05/2025) in the cases of B. (No. 2), Cristian Teodorescu group, Ticu, Parascineti, R.D. and I.M.D. (N. group), N. (No. 2), Centre for legal resources Valentin Campeanu, Atudorei and N. v. Romania (Applications No. 1285/03, 22883/05, 24575/10, 32060/05, 35402/14, 38048/18, 47848/08, 50131/08, 59152/08).

Information made available under Rule 9.2 of the Rules of the Committee of Ministers for the supervision of the execution of judgments and of the terms of friendly settlements.

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Réunion : 1531e réunion (juin 2025) (DH)

Communication d'une O NG (Centre for Legal Resources) (02/05/2025) dans les affaires B. (No. 2), groupe Cristian Teodorescu, Ticu, Parascineti, R.D. et I.M.D. (groupe N.), N. (No. 2), Centre for legal resources Valentin Campeanu, Atudorei et N. c. Roumanie (requêtes n° 1285/03, 22883/05, 24575/10, 32060/05, 35402/14, 38048/18, 47848/08, 50131/08, 59152/08) ***[anglais uniquement]***

Informations mises à disposition en vertu de la Règle 9.2 des Règles du Comité des Ministres pour la surveillance de l'exécution des arrêts et des termes des règlements amiables.

CENTRUL DE RESURSE JURIDICE

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02 May 2025

COMMUNICATION

In accordance with Rule 9.2. of the Rules of the Committee of Ministers regarding the supervision of the execution of judgments and of terms of friendly settlements regarding the a concerning the cases of CRISTIAN TEODORESCU v. Romania (Application No. 22883/05), PARASCINETI v. Romania (Application No. 32060/05), R.D. and I.M.D. v. Romania (Application No. 35402/14), ATUDOREI v. Romania (Application No. 50131/08), N. v. Romania (Application No. 59152/08), TICU v. Romania (Application No. 24575/10), Centre for Legal Resources on behalf of Valentin Câmpeanu (Application No. 47848/08), N. (No 2) (Application No. 38048/18)

by the Centre for Legal Resources

I. Introduction

The present submission is submitted by the Centre for Legal Resources pursuant to Rule 9(2) of the Rules of the Committee of Ministers for the supervision of the execution of judgments and of the terms of friendly settlements. It aims to address and analyse the extent to which, and the manner in which, the general measures imposed by the European Court of Human Rights in the *judgement Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* were implemented by the Romanian Government.

The Foundation Centre for Legal Resources (CLR) is a non-governmental, non-profit organisation, established in 1998 in Bucharest by the Open Society Foundation Romania. In 2016, CLR applied and received the ECOSOC consultative status. CLR actively advocates for the establishment and operation of a legal and institutional framework that safeguards the observance of human rights and equal opportunities, free access to fair justice and which capitalises on its legal expertise for the general public interest. To achieve its objectives, CLR uses advocacy tools such as: monitoring and reporting (CLR has been national focal point for the EU Agency for Fundamental Rights during 2006-2014), campaigning, issuing policy positions and press statements, training relevant professionals and stakeholders, engaging in strategic litigation. As part of its activity, CLR has successfully litigated the case *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania*.

II. Executive Summary

This submission, made by the Centre for Legal Resources (CLR) under Rule 9.2 of the Committee of Ministers' Rules, addresses Romania's failure to implement the general measures required by the European Court of Human Rights (ECtHR) judgment in several cases against the Romanian state. Despite the landmark decisions highlighting systemic failures in protecting the rights of institutionalised persons with mental disabilities, significant issues remain unaddressed by the Romanian authorities.

Key findings reveal severe and ongoing human rights violations, particularly in residential centres for persons with disabilities. Monitoring visits by CLR in 2023 and 2024 uncovered cases of abuse, neglect, and inhumane treatment, notably in centres such as *Căsuța Lu' Min* and others in Ilfov and Mureș counties. Victims were subjected to degrading conditions, physical abuse, and inadequate medical care, resulting in multiple deaths and continued trauma. Additionally, relocations often occurred without assessing victims' needs, leading to further revictimisation in unsafe environments.

Systemic issues identified include the **lack of inter-institutional cooperation**, **absence of independent representation**, **ineffective investigations**, and **insufficient training for professionals**. Communication gaps between social services, healthcare providers, and judicial authorities hinder personalised care and effective legal advocacy. Many victims remain unaware of their rights, and case files lack traceability, making it difficult to ensure accountability and adequate care.

IV. General measures

The communication transmitted by the Romanian authorities on 18 October 2024, regarding the cases that are to be examined during the December 2024 meeting, does not address several aspects related to the obligations imposed on the Romanian state in the two cases that are the subject of this communication.

CLR has been conducting unannounced monitoring visits in residential centres for persons with mental disabilities under the supervision of county-level General Directorates for Social Protection (GDSACP) and under the coordination of the National Authority for Persons with Disabilities (NAPD), as well as in psychiatry hospitals ever since 2004.

A public scandal erupted in the spring of 2023, concerning the conditions in several residential centres in the Ilfov County, which came to be known as the "Asylums of horror". Severe irregularities were discovered in these centres: persons with disabilities were kept in extremely filthy conditions, starved, held against their will, beaten, and their money was stolen. Several public institutions, both local and central, were accused of knowing about the abuse at least since the previous fall, when the CLR carried out monitoring and reporting on

the centres in question, with their main findings being shared with the aforementioned institutions

In July 2023, as a result of a monitoring visit, **CLR uncovered severe abuse and neglect during an unannounced visit to the *Căsuța Lu' Min* residential centre in Mureș County**. Disabled residents were found in inhumane conditions, including confinement in a basement and a locked room, some covered in filth and displaying injuries. Some of the residents mentioned that they had been tied up, threatened, and beaten by the staff and management of the centre, showing specific injuries consistent with being tied at the hands.

In both the case of centres in Ilfov and Mureș, the strong media impact and public pressure prompted the authorities to take urgent action. This led to an exceptional mobilisation, particularly of the judicial and healthcare systems, as well as good regional coordination by the social system, considering the number of victims and the complexity of their situations. Emergency services were called, the centre was closed, and residents were relocated, later becoming part, as victims, of a criminal investigation for human trafficking. Two criminal cases were opened, with several institutions and individuals being indicted and more than 42 victims.

In October and November 2024, CLR conducted monitoring visits to evaluate the situation of the relocated victims[1]. The purpose of the visits was to observe how specific procedures, if they exist, are applied and adapted to the needs of persons with mental disabilities who are also victims in ongoing criminal proceedings.

In October 2024, CLR also requested all 47 GDSACPs (41 county-level and 6 sector-level directorates in the Municipality of Bucharest) to report on the situation of victims with disabilities, in accordance with the national law on transparency[2]. The requests aimed to provide an understanding of the support system for victims with intellectual and psychosocial disabilities who have experienced abuse, addressing their origins, the specific services available, and the procedures followed by GDSACPs upon their entry into the system. They sought details on the involvement of specialists, collaborations with the National Agency Against Trafficking in Persons and other institutions, and GDSACP's role in assisting criminal investigations. Lastly, they explored the use of private social service providers for such victims, including the reasons for selection and contractual arrangements.

A complaint, submitted by the CLR to the Directorate for Investigating Organized Crime and Terrorism – Târgu Mureș Territorial Service (DIICOT ST Târgu Mureș) on December 20, 2024, outlines grave violations of the rights of institutionalized children with disabilities at the Trebely Residential Center in Târgu Mureș, Romania[3]. The children, many of whom were

[1] Reports from the Monitoring visits attached to the file
[2] Responses from GDASCPs attached to the file
[3] See CLR press releases, in Romanian -
https://www.crj.ro/scrisoare-deschisa-adresata-dlui-prim-ministru-marcel-ciolacu/ and
https://www.crj.ro/strigatul-copiilor-cu-dizabilitati-institutionalizati-ilegal-de-catre-dgaspc-mures/

removed from their families solely on the basis of their disabilities, were subjected to inhuman and degrading conditions, including severe neglect, malnutrition, lack of medical care, and the absence of rehabilitative services. Despite significant public funding allocated to the center, living standards were far below legal requirements. The complaint also highlights a profound conflict of interest: the director of DGASPC Mureș, who initiated the institutionalization of these children, later assumed the role of their legal representative, enabling a system of abuse and mismanagement to persist without accountability. According to Romanian legislation, institutionalization of children aged 0 to 7 is strictly forbidden except in cases involving disabilities, lack of community services, and following an evaluation conducted by services subordinated to the same DGASPC director—thereby reinforcing the structural conflict of interest and facilitating the unlawful placement and prolonged institutionalization of vulnerable children.

On January 14, 2025, the DIICOT prosecutor in Târgu Mureș initiated a criminal investigation *in rem* following the complaint submitted by the CLR on December 20, 2024. This came after public pressure, including media inquiries, and an unannounced monitoring visit by CLR and the Council for Monitoring (January, 20th, 2025), which revealed that several children were locked in rooms overnight with bolts, and that food and medication were stored improperly or had expired. Additionally, physiotherapists failed to provide proof of working with children, despite the lack of rehabilitation posing serious health risks. However, the DIICOT communication to CLR did not detail any effective investigative actions by prosecutors, relying instead on official reports from state control bodies (social and medical inspections). Parents and CLR staff were not interviewed, despite reporting they were denied support to care for their children at home and later denied access to them. CLR's analysis also showed that DGASPC Mureș invested public funds in institutionalization (e.g., office staff salaries, public acquisitions) rather than in community-based recovery services or support for foster care. This raises concerns about DGASPC Mureș's interest in maintaining institutionalization practices for both children and adults. Moreover, the President of the Mureș County Council — under which DGASPC Mureș operates — requested the County Police Inspectorate of Mures to investigate those who monitored the children (specifically the CLR program manager) and journalists who widely reported the abuses. A complaint was also filed with the Romanian Parliament against the Council for Monitoring, an autonomous authority under parliamentary oversight. On February 25, 2025, DIICOT Târgu Mureș notified CLR that the case had been transferred to the Prosecutor's Office attached to the Mureș County Tribunal. Since then, CLR has received no further updates on the investigation, and the children involved were relocated to other institutions with similar conditions to those initially reported.

As a result of these activities, the main problems identified, affecting the implementation of the obligations assumed by the Romanian state, were tied to (1) inter-institutional cooperation, (2) independent representation, (3) effectiveness of investigation and adapting

the existing system to the needs of persons with disabilities (4) quality of care afforded to people with intellectual disabilities or with mental health conditions.

1. Inadequate protection of victims' right to life

Even though ten years have passed since the judgement in the *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* case, the Romanian state is still not ensuring adequate protection of the right to life of vulnerable individuals, especially those with mental disabilities.

Out of the victims of human trafficking identified at the *Căsuța Lu' Min* residential centre, **3 persons have since passed away**, all of whom had been kept in the worst condition, in the centre's basement. Another victim has attempted suicide. Others have undergone numerous and continuous involuntary medical hospitalisations. CLR was not able to identify records of all victims and we have been unable to establish traceability of the procedures applied to each individual.

Some victims have been relocated to multiple centres. In at least one of the cases, the victim's new care centre revictimized her, placing her in unmonitored, unsafe environments, such as isolation rooms in psychiatric hospitals or abusive private centres.

One of the victims from the Mureș Centre, who was in the care of GDSACP Sector 6 (Municipality of Bucharest) was abandoned at another private, state-funded centre, the Dales Association in Dridu, Ialomița[4]. A month later, inspectors from the Monitoring Council found her tied up and locked in. Police intervention was required to gain access to the centre, yet this did not prompt action from the leadership of DGASPC S6. The victim was subsequently transferred by ambulance to the Obregia Psychiatric Hospital in Bucharest, where she remained—likely in isolation—from September 2023 to 22 May 2024. DGASPC S6 moved her to a padded room in the Uverturii Centre. The victim was kept there for only a few hours, during which she was fed and cared for by her mother in the isolation room. Later that evening, an ambulance rushed her to the Bucharest Emergency University Hospital, where she was operated on and intubated, but later **passed away on 9 August 2024**.

No incident reports were made, no police involvement was sought, and no investigations into surveillance footage were conducted regarding what happened to her in isolation, suggesting a procedural violation of article 2 ECHR.

Other victims from Mureș County were relocated to the "Ștefan cel Mare" care and assistance centre in Sighetu Marmației, Maramureș. According to the statements offered by the centre's

[4] The case was extensively reported by Carla Tănasie for Digi24, see: https://www.digi24.ro/stiri/actualitate/sanatate/pacient-in-romania/final-tragic-in-cazul-uneia-dintre-victimele-azilelor-groazei-cum-a-salvat-statul-o-tanara-de-19-ani-pana-a-muri-3010301?fbclid=IwY2xjawGyw7RleHRuA2FlbQIxMAABHdQpqvQwwgPel0YPl5FmETN2mx1cLt6bK_Y_IB8JdNkMrTFjiCXTzR_gjA_aem_g42AZcKvayt6Ewjpt66uMw (in Romanian);

staff to CLR, the victims arrived at the centre in July 2023, visibly emaciated, without any documents indicating the medical treatments they required, and showing visible signs of trauma. Two of them, reduced to mere skeletons, later passed away in the centre. Some victims bore signs of restraint on their hands and feet, exhibited automatic defensive reactions when approached by anyone, fought among themselves, and showed clear signs of neglect. Most did not know how to eat with a spoon, were scared when their hands were touched, struggled to sleep, were restless, and screamed during the night. Some were also afraid of the dark.

2. Lack of inter-institutional cooperation - affecting quality of care

The main challenge in ensuring quality of care for the victims lies in systemic gaps and lack of inter-institutional cooperation. There is a lack of clear and consistent communication between agencies, such as GDSACP, healthcare providers, and judicial authorities. This results in incomplete or outdated information about victims, hindering efforts to provide personalised care and effective legal advocacy. Lack of traceability, scattered documentation and the absence of comprehensive, unified case files limited the ability of multidisciplinary teams to coordinate and address victims' specific needs.

In several cases, the professionals working in the residential centres were unaware, either from prior interactions with the victims or from any document, of the conditions in which the victims had been previously housed or of any specific documents prepared regarding them, considering that most came from the social system. The judicial authorities did not communicate with the centres' staff members to provide essential information regarding how the victims had been treated during the time they were trafficked, details that would have been useful for a personalised approach to each victim.

In one centre, the staff, including the head of the centre, stated that they were unaware of the victim status of the targeted beneficiaries—an issue reflecting either a severe communication failure within the system or a lack of cooperation with the CLR team.

In one of the centres that received a large number of victims by decision of the authorities, staff members were not provided with information about the victims' medical treatments, as they were considered documents pertaining to the investigation. Given their medical conditions, the staff experienced difficulties, especially during the first weeks, in managing the victims. On one hand, the victims did not have appropriate medical treatment (the explanation provided was that the entire file had been handed over to the judicial authorities, and it took two months to obtain the necessary information from it, during which time the specialist doctor prescribed alternative medications). On the other hand, the victims exhibited behaviours that the centre's staff were unfamiliar with, as they had not been informed about the conditions in which the victims had been previously housed.

The judicial authorities did not see fit to adapt their procedures in their interactions with the structures managing the victims (for example, by not seizing the original medical documents or, where appropriate, by releasing them more promptly).

In another case, according to the statements of the centres' staff members, the victims arrived with documents mentioning the medical treatments they required, but without any indication of their status as victims. In another case, they arrived without any documents at all.

3. Lack of training of professionals - affecting quality of care

The lack of training among professionals poses significant challenges to the quality of care provided to victims with intellectual and psychosocial disabilities. Many staff members in social care centres and medical facilities lack specialised knowledge about trauma-informed approaches, behavioural management, and effective communication with nonverbal or severely traumatised individuals.

Staff members of several centres where the victims were relocated reported to CLR that no representative from a specialised agency (e.g., the National Anti-Trafficking Agency) came to engage in dialogue or provide them with guidance on how to approach the victims.

Centres' staff members were not trained to identify cases of gender-based violence in particularly vulnerable cases, such as the ones involving non-verbal victims. In at least one case, the centre's staff members has not been trained to use pictograms to communicate and ask if the victims have been subjected to sexual assaults, even though .

In the case of a centre in Covasna County, the centre's resident doctor stated that they were not specialised in psychiatry and highlighted the inappropriateness of mixing severe psychiatric cases—such as grafted schizophrenia, schizophrenic disorders, and personality and behavioural disorders—with the other beneficiaries of the centre. The staff at the centre were not trained to manage such cases, and the two beneficiaries who were brought in (no specific details were provided) posed a danger to both the other beneficiaries and the staff. This demonstrates that the centre's staff neither had the capacity nor the availability to care for some of these victims, a fact they documented in writing.

4. Independent representation

Victims' representation often relies on the same case managers or guardians who were present during periods of mistreatment, raising concerns about conflicts of interest and accountability. The absence of independent oversight mechanisms or specialised advocates further exacerbates this issue. Many victims are unaware of their rights, lack the means to challenge decisions affecting them, and remain dependent on institutional structures that have

previously failed them. Without addressing these systemic issues, true independent representation remains difficult to achieve.

In some cases, case managers did not make the necessary efforts to share basic information and connect the data, engaging only formally in handling the situations of these victims. In many cases, the same case managers who were responsible during the period when the victims were subjected to offences have failed to manage these cases properly and continue to do so. In some cases, all victims relocated to a certain residential centre were under the representation of the same GDSACP - sector 3 (Municipality of Bucharest).

In the case of the victim that passed away in August 2024, after months of isolation, GDASPC sector 6 (who was providing legal representation for the victim) completely refused cooperation with CLR. In one instance, GDASPC called 112, citing that CLR representatives were not supposed to be in the director's office, prompting a police response involving 12 officers. During this meeting, CLR representatives presented the DIICOT Mureș prosecutor's ordinance recognising CLR's legal standing to represent the victims and the Monitoring Council protocol. Despite this, GDASCP continued to deny CLR access to information, continuing its opaque practices regarding the protection of individuals with mental disabilities. The leadership, alongside the mayor of Sector 6, appears not to understand the legal rights of these individuals, often placing them in psychiatric hospital isolation rooms or abusive centres like Dridu and Bărdești, instead of creating specialised services within Sector 6.

5. Lack of training of relevant law enforcement, social work, and medical professionals

Ensuring the effectiveness of investigations and adapting the existing system to the needs of persons with disabilities faces several key challenges. One significant issue is the lack of specialised training for professionals involved in the process, including police, case managers, and healthcare providers, many of whom are not equipped to communicate effectively with individuals with intellectual or psychosocial disabilities. This lack of training may lead to inadequate documentation of testimonies and difficulties in gathering critical evidence, thereby undermining the quality of investigations.

In several cases, there was no traceability of the files, and the victims' behaviour prior to the events under investigation in the human trafficking case is unknown, making it impossible to determine whether some of the subsequent behaviours are a result of the mistreatment they were subjected to on that occasion or due to earlier events.

6. Inter-institutional cooperation - effective criminal investigation

In two of the centres visited by CLR, the number of victims accommodated in that centre was not up to date. In one case, according to the Directorate for Investigating Organised Crime

and Terrorism (DIICOT) - Central Structure, there were supposed to be 35 victims accommodated, but only 2 individuals from the case were present in the centre (Ilfov County). In another case, 8 victims were supposed to be accommodated in a specific centre, but 15 were actually housed there (Giurgiu County).

In centres in the Maramureș and Covasna Counties, where most of the accommodated victims were non-verbal, judicial authorities were present only once, during which it was found that communication with the victims was impossible, a fact that was also documented in the files related to the criminal case. There are no mentions of law enforcement attempting to use alternative means to communicate with the victims.

Out of the victims whose files CLR had access to during the monitoring visits, only one had a document in the case file—a report dated 15 November 2023— attesting that their rights as a victim in the criminal case were communicated by the judicial police investigator. No other similar reports were identified in the other victims' files.

V. Conclusions and recommendations

Having in mind the seriousness of the human rights violations identified in this group of cases, and the fact that this judgement has been pending implementation for 10 years, the CLR points out to the continuing ineffectiveness of the legal remedies available to protect the rights of institutionalised persons with disabilities in situations of vulnerability.

As a consequence, we would like to highlight some recommendations that we consider essential to be made by the Committee of Ministers for the Romanian Government to ensure that the persons with intellectual and/or psychosocial disabilities' rights are guaranteed by effective and functional safeguards:

1. **Access to Justice for Institutionalized Children with Disabilities in Mureș County** We respectfully request the Committee of Ministers to call on the Romanian Government to provide detailed information regarding the measures taken to ensure effective access to justice for children with disabilities and their families affected by institutionalization in Mureș County. This should include clarification on whether families and independent monitors have been heard in the course of investigations, what procedural safeguards were applied, and how victims are supported in seeking remedies for the alleged abuse, neglect, and unlawful separation.
2. **Prevention of Exploitation and Institutional Abuse.** We urge the Committee of Ministers to ask the Romanian Government to explain what concrete steps have been taken to prevent the exploitation and potential trafficking of children and adults with disabilities placed in residential institutions in Mureș County. Particular attention should be paid to how conflicts of interest are addressed, especially in cases where the same authority both orders institutionalization and serves as legal representative. The

Government should also be asked to report on the development and funding of community-based services and support for family-based care as alternatives to institutionalization.

3. **Conflict of Interest in Guardianship and Placement Decisions**. We request the Committee of Ministers to ask the Romanian Government to explain what legal and procedural safeguards are in place to prevent conflicts of interest in cases where the director of the General Directorate for Social Assistance and Child Protection (DGASPC) orders the removal of children with disabilities from their families. Specifically, the Government should clarify how it ensures the child's right to independent legal representation, given that in many cases, children are represented by the DGASPC's legal advisor—who also represents the DGASPC director that initiated the placement—and that director often becomes the child's legal representative, raising serious concerns about impartiality.
4. **Protection of Adults with Disabilities in Institutional Care**. We ask the Committee of Ministers to request the Romanian Government to clarify what mechanisms are in place to prevent similar abuses against adults with disabilities who remain institutionalized in the same centers after aging out of the child protection system. In many cases, these individuals are placed under full guardianship, with their legal guardian being an employee of DGASPC or a municipal official. The Government should explain how it safeguards the rights and autonomy of these adults, prevents arbitrary deprivation of legal capacity, and ensures access to independent support and legal review.
5. **Developing a comprehensive and unified file**, in order to ensure traceability of medical information. All scattered documents concerning the victims must be compiled into a complete file containing detailed information on the medical history, diagnoses, treatments, prior interventions, and specific needs of each victim.The file should be accessible to the centres' multidisciplinary teams to ensure continuity of care and facilitate coordination among specialists.
6. **Ensuring that relocations of victims are preceded by a thorough assessment** of their specific needs. Avoid placing them in inadequate facilities or centres that do not provide tailored services. While such relocations might be justifiable for short-term emergencies, they are unacceptable for medium or long-term care.
7. **Ensuring that all victims receive regular psychological counselling** tailored to their specific needs. Address the inadequacies in interventions for trauma and comorbidities by providing specialised care. Additionally, implement daily activities that offer cognitive and motor stimulation to promote the well-being and recovery of victims.
8. **Ensuring legal representation for all victims** and addressing the ongoing lack of clarity regarding guardianship status. Avoid potential conflicts of interest when appointing the victims' legal representative.
9. **Ensuring that all victims are properly informed of their rights**. The current practice is inadequate, as only one case was identified where the case file contained a

document confirming that the victim had been informed of their rights in the criminal proceedings. Consistent and documented communication of rights must be standard practice for all victims.

10. **Organising training and education sessions for centre staff** on handling victims with complex trauma and raising awareness of issues specific to human trafficking victims. The National Anti-trafficking Agency and other similar stakeholders should be involved in these efforts.
11. **Developing interinstitutional collaboration protocols and information-sharing mechanisms** between various agencies involved (GDSACP, National Anti-trafficking Agency, medical teams) to improve the quality of care and ensure the effectiveness of criminal investigations.

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