FOLKETINGETS
OMBUDSMAND

OPCAT Annual Report 2011

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Contents

1. The Ombudsman as National Preventive Mechanism in 2011

In 2011 the Ombudsman focused his work especially on the issue of degrading treatment of children and juveniles who were or might be deprived of their liberty. Consequently, most of the year's visits, which are the Ombudsman's most important instrument, took place in institutions for children and juveniles. In addition, the Ombudsman made use of his right to visit private institutions.

The overall impression was that the visited institutions were characterised by professional ability and respect for the children, the juveniles and other users of the facilities, and that the users were treated well and with an extensive consideration for their individual needs.

Most visits were concluded without the Ombudsman finding any grounds for written remarks to the responsible authorities.

The visits also uncovered problematic issues which the Ombudsman subsequently raised with the relevant authorities. One instance was based on visits to psychiatric wards for children and juveniles where the Ombudsman asked the Ministry of Health and the Ministry of Justice some questions concerning the legal basis for searches and confiscation on psychiatric wards. Likewise, the Ombudsman now has a special focus on the legal status of children and juveniles in connection with the use of force in the psychiatric setting.

The visit to the secure residential institution 'Grenen' showed that in at least two instances juveniles had been subjected to unreasonable treatment by the staff. Certain socioeducational care facilities used a variety of measures, such as asking the juveniles to submit a urine specimen for examination or in certain cases limiting the juveniles' use of and access to i.a. mobile phones, computers and/or the internet. The Ombudsman raised various fundamental questions about the use of these measures with the Ministry of Social Affairs and Integration.

In addition, the Ombudsman investigated cases regarding the exchange of health information by local prisons and on local/regional differences in the use of solitary confinement in prisons.

The Ombudsman carries out his work against degrading treatment pursuant to a UN protocol (statutory instrument No. 38 of 27 October 2009 about the optional protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, abbreviated as OPCAT) in cooperation with DIGNITY (formerly the Rehabilitation and Research Centre for Victims of Torture) and the DIHR (Danish Institute for Human Rights).

2. Monitoring visits during the year

2.1. General

In 2011 the Ombudsman carried out the following OPCAT monitoring visits:

'FM Huset på Amager' (socioeducational accommodation facility)	12 May 2011
'Sølager' (secure residential institution)	18-19 May 2011
Bispebjerg Psychiatric Centre for Children and Juveniles	31 May 2011
'Projekt Start' (socioeducational accommodation facility)	7 June 2011
Glostrup Psychiatric Centre for Children and Juveniles	14 June 2011
Roskilde Mental Health Services	14 June 2011
'Landbasen' (socioeducational accommodation facility)	17 June and 23 August 2011
'Koglen' (secure residential institution)	20 June 2011
'Grenen' (secure residential institution)	21 June 2011
Næstved Mental Health Services	27 June 2011
'Egely' (secure residential institution)	28-29 June 2011
Holbæk Mental Health Services	12 July 2011
Police holding cells at Station City	26-27 August 2011
Police holding cells at Station Amager	26-27 August 2011
Police holding cells at Station Bellahøj	26-27 August 2011
'Bakkegården' (secure residential institution)	25 October 2011
'Politigårdens Fængsel' (local prison)	28 October 2011
'Fonden Kanonen' (socioeducational accommodation facility)	7-8 November 2011
'Aktiv Weekend' (socioeducational accommodation facility)	23-24 November 2011
'Stevnsfortet' (secure residential institution)	30 November 2011
'Dorthe Mariehjemmet' (nursing home)	2 December 2011
'Respons' (socioeducational accommodation facility)	14 December 2011
'Nelton' (socioeducational accommodation facility)	14 December 2011
'Himmerlandsskolen' (socioeducational accommodation facility)	15 December 2011

'Grenen' (follow-up visit to secure residential institution)	15 December 2011
'Højdevangs Sogns Plejehjem' (nursing home)	21 December 2011

The visits included 3 police station holding cells, 1 local prison, 10 psychiatric wards, 16 socioeducational accommodation facility branches, 22 secure residential home branches, 2 nursing homes and one follow-up visit to a secure residential institution.

Most of the institutions were part of the public administration.

Five visits (the visits to the police station holding cells, the local prison and the follow-up visit to the secure residential institution) were made without advance notice while the other visits were carried out with advance notice. All visits were carried out during the daytime on weekdays except the 3 visits to the police station holding cells which took place at night between a Friday and a Saturday.

The institutions were very cooperative and helpful towards the visiting teams, even in the case of the visits to the police station holding cells (regardless of the fact that these visits were made without advance notice during the night between Friday and Saturday) and in the case of the other unannounced visits.

All visits except two (the visits to the Højdevang Sogn nursing home and the Roskilde Mental Health Services) were carried out with medical assistance from DIGNITY. The DIHR did not participate in the visits.

During all the visits the visiting teams had interviews with the institutions' management. The visiting teams spoke with the users, including residents, inmates and patients, during all the visits, except for the visit to the 'FM Huset' and the visits to the holding cells. As the holding cells were empty at the time of the Ombudsman's visit, there was no opportunity for the visiting teams to interview any inmates in the cells. No residents at the 'FM Huset' wished to speak with the visiting team. The visiting teams spoke with a total of 103 users in 2011. During most of the visits the visiting teams also spoke with the daily staff and during many visits also with relatives of the users. In the case

of a number of visits the healthcare staff was also interviewed. The relevant supervisory authority was represented during most of the visits.

Most visits were concluded without the Ombudsman finding grounds for making any written remarks to the responsible authorities.

2.2. Number of visits

In 2011 the Ombudsman decided to calculate the number of his monitoring visits so that, following specific assessment of the conditions in the individual case, a visit to a single branch of an institution would count as an independent visit, also where several of the institution's branches were visited at the same time. When making the specific assessment, the Ombudsman paid particular attention to the extent to which the branch in question differed from the institution's other branches with regard to clientele, underlying rules, organisation and activities of the branch, and management structure. Also the branch's geographical closeness or distance in relation to the institution's other branches was included in the assessment.

Previously, the Ombudsman had calculated the number of visits based on the number of institutions visited, no matter how many branches of the institution the Ombudsman actually visited. A visit to for instance a State Prison therefore only counted as one single monitoring visit no matter if the Ombudsman visited one, several or all blocks in the prison and no matter how much time was devoted to the visit.

It is in this context important to note that in some instances it was more useful to visit one branch or a few branches in an institution. In other instances it made more sense to visit all branches in an institution. What suited the situation best was entirely dependent on the purpose of the visit and the individual institution. If the Ombudsman's purpose in visiting the institution was to investigate the conditions for children and juveniles, and all the institution's branches accommodated this target group, then the Ombudsman would normally visit the whole institution, regardless of whether the institution was geographically spread out with branches in a number of towns, and no matter if the visit took one or several days. Vice versa, if the visit's target group was only to be found in one of the institution's branches, the Ombudsman would often choose to visit just this one branch.

On this basis the Ombudsman decided to calculate his OPCAT monitoring visits so that a visit to an individual branch of an institution according to a specific assessment counted as an independent visit. At the same time the Ombudsman decided to increase the number of visits with the effect that, pursuant to the UN protocol, the Ombudsman visits about 50 branches a year. In 2011 the Ombudsman carried out monitoring visits to 55 branches. The visits comprised of 25 institutions.

2.3. Theme

Following discussions with DIHR and DIGNITY, the Ombudsman decided that the 2011 theme for the OPCAT monitoring visits would be children and juveniles who were or might be deprived of their liberty. The decision meant that the majority of monitoring visits in 2011 took place at institutions where there were – or where there could be – children and juveniles deprived of their liberty.

Choosing this theme gave the Ombudsman the opportunity to focus on children and juveniles deprived of their liberty and to gain experience and knowledge of and insight into the everyday life of these children and juveniles and the issues pertaining to this group. Besides, children and juveniles are generally more vulnerable than other groups, and there may be special legal challenges by virtue of the fact that children and juveniles are underage and (generally) legally minors and thereby subject to parental authority.

Children and juveniles may be deprived of liberty for a variety of reasons and in various types of both public and private institutions. The Ombudsman chose to examine his theme of children and juveniles deprived of their liberty by visiting various types of institutions – psychiatric wards for children and juveniles, socioeducational accommodation facilities and secure residential institutions. The Ombudsman visited several institutions of the same type in order to gain insight in the ways in which the same type of institution could be operated, and to see how similar institutions dealt with the same tasks and challenges. In addition, the Ombudsman wished to visit both public and private institutions. The psychiatric wards for children and juveniles and the secure residential institutions come under the public administration while the socioeducational accommodation facilities were (generally) private.

Besides the visits generated by the theme of children and juveniles, the Ombudsman visited 3 police station holding cells, 1 local prison and 2 nursing homes in 2011.

2.4. Visits to psychiatric institutions for children and juveniles

The Ombudsman visited inpatient units for older children, inpatient units for patients with eating disorders, open inpatient units for juveniles and closed inpatient units for juveniles at Bispebjerg Psychiatric Centre for Children and Juveniles under Capital Region Denmark's Mental Health Services. At Glostrup Psychiatric Centre for Children and Juveniles, which also falls under Capital Region Denmark's Mental Health Services, the Ombudsman visited the school children's unit and the open and closed youth psychiatric units. In addition, the Ombudsman visited the Roskilde Mental Health Services youth psychiatric unit, the Holbæk Mental Health Services Centre for Eating Disorders and the Næstved Mental Health Services psychiatric inpatient unit for children and juveniles, all under 'Psykiatrihuset', Region Zeeland Mental Health Services.

One of the characteristics of psychiatric wards is that various forms of coercion may be used towards the patients, for instance confinement, compulsory treatment, forced immobilisation and the use of physical force. The patients are typically admitted to a psychiatric ward for a period of time because they have a serious psychiatric disorder which requires treatment.

The visits to the Glostrup Psychiatric Centre for Children and Juveniles, the Roskilde Mental Health Services and the Holbæk Mental Health Services were concluded without the Ombudsman finding any grounds for written remarks to the responsible authorities.

Two incidents took place during the Ombudsman's visit to the Næstved Mental Health Services psychiatric inpatient ward for children and juveniles. According to information received, both incidents were triggered by the patients being told that they were to be released. One of the incidents was an attempted suicide. The other incident concerned the use of force to restrain a 13-year old patient who was breaking furniture, grabbing hold of the staff and kicking out. The patient's behaviour resulted in the staff using force towards the pa-

tient, as the staff twice brought the patient to the bed and restrained the patient there.

The Ombudsman made a detailed investigation of the incident involving the use of force and remarked in his closing letter that the incident made him consider whether he should take up the issue of the legal rights of minors vis-à-vis the Mental Health Act, particularly in relation to the act's concept of force in section 1(1-4), with the Danish Health and Medicines Authority and the Ministry of Health. On this basis the Ombudsman concluded the visit without finding grounds for any written remarks to the responsible authorities.

During the tour of the ward for eating disorders at the Bispebjerg Psychiatric Centre for children and juveniles the Ombudsman's monitoring team noticed an incident involving the use of force as the team from the windows of the ward looked out into an enclosed courtyard with a playground where a patient was restrained and by force led into the unit for older children. The patient was resisting. Later on during the tour of the ward for older children, the monitoring team went past the room where the patient was with one or more staff. Through the closed door the team heard the patient yelling, crying and screaming. Subsequently, the Ombudsman asked for statements about the incident from the Bispebjerg Centre, the Mental Health Services of Capital Region Denmark and the Health and Medicines Authority. The Ombudsman is waiting for statements from the authorities, and the case was thus pending when this report was submitted.

On the basis of visits to psychiatric wards for children and juveniles the Ombudsman has focused particularly on the use of force in psychiatric treatment. Furthermore, several visits to psychiatric wards for children and juveniles brought to the Ombudsman's attention some problems relating to section 19a of the Mental Health Act and its legal basis for the wards' searches of rooms and persons and confiscation of possessions. The Ombudsman took up this issue with the Ministry of Health (formerly the Ministry of the Interior and Health) and the Ministry of Justice, cf. heading 3.2. below.

2.5. Visits to secure residential institutions

The Ombudsman visited 6 secure residential institutions.

A secure residential institution for children and juveniles comprises at least one secure unit and may have one or more specially secured units.

A secure unit can keep outer doors and windows locked constantly and may obtain permission to lock the rooms at night. Young people may be placed in a secure unit for instance when it is necessary in order to prevent the young person from self-harm or from harming others and it has not been possible in a safe way to prevent this risk by using other and more gentle measures, when the stay is a substitute for remand, when the stay is part of a sentence, or when the young person is an alien under 14 years of age without legal residence in Denmark.

Juveniles are placed in a specially secure unit when placement in a secure unit is not or will not be sufficient. In secure and specially secure units physical force may be used in the form of restraint, solitary confinement and search of the person or room of the juvenile.

Apart from the visits to the secure residential institution “Grenen”, all monitoring visits were concluded without the Ombudsman finding grounds for making any written remarks to the responsible authorities.

The Ombudsman visited “Grenen” twice in 2011, first as an advance notice visit and then as a follow-up visit with no advance notice. The visits provided the Ombudsman with information which gave him the grounds for investigating the following issues:

- The use of force, including the number of times illegal force had been used, and statements about the use of force which “Grenen” should have reported but did not
- Two incidents which took place on 13 and 20 June 2011, respectively
- Suspicion of possibly degrading conditions

In relation to the information about the illegal use of force, the Ombudsman gave a written recommendation to “Grenen” that the institution in future be mindful of the general legal framework for the institution, including in particular those regulations and principles that protect the rights of children and juveniles.

It turned out that in at least two instances residents at “Grenen” had been subjected to unreasonable treatment by staff members. “Grenen” and Central Region Denmark reacted quickly and appropriately by, i.a., giving written warnings to the staff members involved in the episodes.

In one incident the staff had asked 3 young people to remain in their rooms between 9 a.m. and 3 p.m. because the staff ratio was poor due to errors in the duty roster. Under normal circumstances there would be activities for the residents, i.a. lessons, ball games, computer games and communal cooking. “Grenen” called it unacceptable and not compatible with the institution’s values that the residents were asked to remain in their rooms on the day in question.

In another incident the staff had played a sort of blind man’s buff with a resident which resulted in an unpleasant situation for him. The staff had promised the resident that he would be allowed to phone his mother if he blindfolded could find a hidden telephone. When the resident found the telephone, he was not allowed to phone his mother after all, as he was banned from phoning home. Having reviewed the incident, “Grenen” wrote that if it was correct that the resident had been promised that he would be allowed to phone home, and the promise had not been fulfilled, then this constituted offensive or degrading treatment.

With regard to the suspicion of any degrading incidents the Ombudsman remarked that “Grenen” had implemented a number of forward-acting initiatives, including the following: Management had impressed upon the staff the focus on maintaining and improving an appropriate and correct language usage and on preventing an inappropriate and degrading usage; the furnishings on the secure and specially secure units had been changed so that the residents themselves chose whether or not they wanted to have urine bottles in their rooms; and management had introduced new rules and procedures for the staff’s use of certain educational tools with a view to ensuring that the use was based on professional grounds and as meaningful educational measures.

The Ombudsman subsequently concluded his visits to ”Grenen”.

Regardless of the fact that he uncovered problematic conditions at “Grenen”, the visits to the 6 secure residential institutions did not give the Ombudsman grounds for general concern.

2.6. Visits to socioeducational accommodation facilities

The Ombudsman visited a number of socioeducational accommodation facilities for juveniles. The facilities were organised as partnerships, individual proprietorships, foundations/non-profit institutions or limited liability companies, and were therefore (as a general rule) private. Through the visits to these socioeducational accommodation facilities the Ombudsman gained insight into the way in which private operations ran institutions for juveniles and dealt with the tasks and problems involved. For these visits the Ombudsman used the amendment to the Ombudsman Act, act No. 502 of 12 June 2009, which allows him to investigate conditions for persons deprived of their liberty in private institutions, etc.

The use of physical force, where the juvenile is held or led to another room, is allowed in residential institutions if the juvenile exhibits such a behaviour that it would be irresponsible to let him or her remain in the communal rooms, or if the action prevents the juvenile from self-harm or from harming others. Residential institutions also allow searches of, for instance, the juvenile’s person or room.

Most visits to the accommodation facilities were concluded without the Ombudsman finding it necessary to make any written recommendations to the responsible authorities.

The Ombudsman visited the socioeducational accommodation facility ‘Landbasen’ on 17 June and 23 August 2011. Following the Ombudsman’s first visit the Holbæk municipality carried out an unannounced inspection of the facility on 4 August 2011. The report on the municipality’s inspection contained a number of comments on, among other things, the physical environment for the residents, and in the report the municipality ordered the facility to, among other things, install fire alarms and to forward documentation that the residents had received instructions regarding procedures and evacuation in the event of a fire and that the physical environment had been approved by the municipality’s Technical and Environmental Administration.

The Ombudsman did not have grounds for making any written comments to the 'Landbasen' facility and the responsible authorities, as the municipality and the facility were in the process of following up on the inspection report. However, the Ombudsman did ask the municipality to keep him informed of developments following the inspection report. The municipality subsequently informed the Ombudsman that it had not been possible to approve the physical environment as sufficiently in keeping with the times for an approved accommodation facility, and that the 'Landbasen' and the municipality had agreed that the facility be discontinued as an accommodation facility for juveniles with effect from 31 December 2012. On this basis the Ombudsman took no further action in the matter.

Following the visit to the socioeducational accommodation facility 'Fonden Kanonen' the Ombudsman instituted an investigation of various matters and asked for a statement from the facility and from the Favrskov municipality which was responsible for the operational supervision of the facility. Among other things, the Ombudsman asked the facility and the municipality for their comments on whether the use of certain educational measures had been professionally assessed and whether there was a legal purpose in carrying out educational measures by force. In addition, the Ombudsman asked for an account of the number of times when the facility had reported the use of force to the municipality, as there was a discrepancy between the facility's and the municipality's figures. The Ombudsman also asked for an account of the system of room inspections.

During the visit the facility stated that the police was in the process of investigating a rape which had been reported by the staff and where the offender, a young man, and the victim, a young woman, were both living in the same unit in the facility. The Ombudsman asked the facility to give an account of the way in which the incident was handled, including an explanation for the facility's decision to allow that the two young people stayed on in the same unit. The reason for the Ombudsman's question was that a preliminary assessment would seem to indicate that it was not in the best interests of either the young woman or the young man to live in the same unit. In addition, the Ombudsman asked for an account of the therapy excursion which the young woman said that the facility had made her go on after she had told the staff about the rape.

The facility and the municipality have given statements in the case which was still pending when this annual report was submitted.

Following the visit to the socioeducational accommodation facility 'Aktiv Weekend', the Ombudsman was informed that the facility could not send the Ombudsman printouts from its daily log regarding several matters because a computer was no longer functioning. In a letter to the facility the Ombudsman noted the facility's information given over the telephone that a system had been introduced whereby daily log notes were saved on a central server with back-up and that internal guidelines had been instituted according to which the staff were not allowed to use the local drives to save daily log notes but had to use the central server. On this basis the Ombudsman took no further action but pointed out that the information might be subject to the duty to take notes pursuant to the principles in section 6 of the Access to Public Administration Files Act and to the non-statutory principle regarding the public authorities' duty to take notes. Furthermore, it was the Ombudsman's opinion that processing of the information would be subject to section 41(3) of the Act on Processing of Personal Data whereby the person responsible for the data shall implement the necessary technical and organisational security measures against the accidental or unlawful destruction, loss or impairment of information and against unauthorised disclosure, abuse or other processing in violation of the provisions laid down in the Act.

In his letter to 'Aktiv Weekend' the Ombudsman also asked the facility for, among other things, an account of the educational knowledge and experience that formed the basis for the use of some of the educational measures, and how the facility ensured that these measures were carried out in a way that ensured the health and safety of the residents. The Ombudsman also asked the Silkeborg municipality, as the supervisory authority for the facility, for a statement. The Ombudsman has not received any statements from the facility or the municipality on these matters, and the case was still pending when this report was submitted.

Three out of 8 visits to socioeducational facilities uncovered conditions which gave the Ombudsman cause for further investigation. In addition, the visits to socioeducational accommodation facilities showed that certain residential facilities used various measures in the form of, for instance, a demand that the

juveniles submit urine samples, and in the form of restrictions in some instances of the residents' use of and access to, i.a., mobile phones, computers and/or the internet. The use of these measures raised various fundamental questions which the Ombudsman subsequently took up with the Ministry of Social Affairs and Integration, cf. item 5 below.

On this basis the Ombudsman decided that he in 2012 was going to focus on, i.a. private institutions.

2.7. Visits to police station holding cells

The Ombudsman made unannounced visits to the Copenhagen Police holding cells at the City, Amager and Bellahøj police stations a night between Friday and Saturday in August. The purpose of making the visits without advance notice and at night was to gain insight into the conditions for people placed in the holding cells at a time when there was likely to actually be detainees in the cells.

Police station holding cells are used when the police need to take care of persons who are unable to take care of themselves, either due to the intake of alcohol or other intoxicants or drugs, or who are encountered in circumstances which are endangering the individual in question, other members of the public, or public order or safety. If less coercive measures are not sufficient to avert the danger, the police may if necessary temporarily detain the intoxicated person in a holding cell.

There were no detainees in the holding cells at the time of the visits, and all three visits were concluded without the Ombudsman finding cause for making written remarks to the responsible authorities.

2.8. Visits to local prisons

The Ombudsman visited the local prison for 25 inmates at national police headquarters (Politigårdens Fængsel), which since 2004 has been used as a special local prison for, i.a., negatively strong prisoners who behave in a violent or threatening manner towards others. Following the visit the Ombudsman started an investigation of the decisions by the Politigårdens Fængsel for a so-called increased level of security for certain prisoners and asked the Politigårdens Fængsel, the Copenhagen Prisons and the Prison and Proba-

tion Service for statements in the case. The reason for this request for statements was that the Ombudsman understood from the visit that prisoners subject to an increased level of security had diminished possibility of participating in activities and/or having social contact in the prison and that such prisoners were confined to their cells for 23 hours a day. Apart from the issue of an increased level of security, the Ombudsman did not receive information which gave him grounds for making any written remarks to the authorities responsible for the Politigårdens Fængsel. The Ombudsman has received the requested statements from the authorities in the case which was still pending at the time of this report's submission.

2.9. Visits to nursing homes

The Ombudsman visited two nursing homes which were run by foundations/independent institutions. The nursing homes had both somatic wards and wards for residents with dementia.

Nursing homes may use various forms of force, for instance securing a person when attending to hygiene tasks for the person, or using personal alarm and location systems. In addition, the municipality or the social board may decide that a person must reside in a specific nursing home without that person's consent.

Both visits were concluded without the Ombudsman finding grounds for making any written remarks to the responsible authorities. The visits caused the Ombudsman to choose as his focus in 2012 i.a. elderly citizens who were or could be deprived of their liberty.

3. Investigations

3.1. Status on already initiated investigations

On 28 September 2010 on his own initiative the Ombudsman asked for statements from the Prison and Probation Service, the Data Protection Agency and the Ministry of Health (formerly the Ministry of Interior and Health) regarding the disclosure of information contained in medical records of local prison inmates which the prison doctor used in the treatment of the inmates. The Ombudsman alluded to the disclosure inherent in the fact that not only

the prison doctor but also other persons had access to the records and to using the information. The hearing was based on, i.a., the information gathered by the visiting teams during visits to local prisons.

From the authorities' description of the rules governing the passing-on of health information in the local prisons it was evident that the provisions in the Health Act concerning information disclosure took precedence over the provisions in the Act on Processing of Personal Data because the Health Act provided better protection than the Act on Processing of Personal Data. The Health Act applies to health staff, which was in the first instance authorised professionals such as doctors and nurses, but according to the Ministry of Health also anyone acting on behalf of an authorised healthcare worker. This could for instance be a prison officer handing out medicine on behalf of the doctor. If the Health Act was not applicable, for instance because the passing-on of information was done by other than healthcare staff, the Act on Processing of Personal Data was used.

The Data Protection Agency stated that the processing provisions in the Act on Processing of Personal Data were not applicable if the special legislation stipulated a specific form of processing of the information. In such cases the special legislation was applicable.

Executive order No. 374 of 17 May 2001 on health assistance for inmates in institutions under the Prison and Probation Service stipulated that notification of police, institution staff or relatives was allowed in certain circumstances. The Department of Prisons and Probation stated that notification of staff and relatives was only allowed if the inmate had consented. Consequently, the executive order's provisions provided the inmates with a better protection against the passing-on of information than the Health Act did, as passing-on of information without consent was possible in certain circumstances according to the Health Act.

With regard to notification from health care staff in a local prison to the emergency service doctor, it was the opinion of the Ministry of Health that pursuant to section 41 (2)(i) of the Health Act notification without consent was allowed when it was necessary due to an on-going treatment regime and when the notification was done with regard for the patients' interests and needs. The

assumption was therefore that health care staff in the prison was allowed to pass on information to the emergency service doctor. However, the inmate could at any time insist that the emergency service doctor not be informed.

This account of the present state of the law did not give the Ombudsman grounds for taking further action in the matter.

At the end of 2010 stories appeared in the media that during police operations in connection with actions against demonstrators at the climate summit meeting in Copenhagen in December 2009, certain police operations commanders had allegedly used language of a somewhat unusual kind. Thus, one commander was quoted as having given, i.a. this order to the police officers: “And I want to see your fucking batons glow red hot when we are going up to get that car. Both barrels through all that shit. Over and out.” The quotes were allegedly a transcript of the police internal radio communications. On 22 December 2009 the Ombudsman asked the Ministry of Justice for a statement.

After reading the Ministry’s statement the Ombudsman concluded the case. He emphasised that the quotes were part of police internal communications; that about 12 months had passed since the quotes appeared in the media; that the context in which the operations commanders’ utterances had been made was uncertain; and that the two latter points created evidential problems which the Ombudsman institution was not equipped to resolve.

3.2. New investigations

In a letter of 11 January 2011 the Ombudsman asked the Ministry of Justice and the Director of Public Prosecutions for a statement regarding any local/regional differences in the use of solitary confinement. The reason for the request was that not insignificant local differences in the use of solitary confinement had been mentioned in report No. 1469/2006 on remand custody in solitary confinement and in the Director of Public Prosecution’s report of 30 March 2010 on the use of solitary confinement in 2008.

The Director of Public Prosecutions said, i.a., that the analyses of the Research Office at the Ministry of Justice showed a continued local/regional variation in the incidence of solitary confinement. According to the Director of Public Prosecutions it was not possible to account in more detail for the rea-

son for the local/regional differences. The Director of Public Prosecutions also pointed out a number of factors which might have an impact on the use of solitary confinement.

The Director of Public Prosecutions stated that no juveniles under the age of 18 were placed in solitary confinement in 2009 and that it was not possible to say whether there had previously been local or regional differences with regard to solitary confinement of juveniles under 18. The Director of Public Prosecutions sent a copy of his statement and of the Ombudsman's letter to the regional public prosecutors and directed their attention to the local/regional differences in the number and share of solitary confinements in remand custody so that the regional public prosecutors could, when occasioned to do so, address the issue in connection with their review of the processing of criminal cases in the individual police districts. The Ministry of Justice relied on the statement from the Director of Public Prosecutions and said i.a. that the incidence of solitary confinements in 2009 had fallen to 210, and that the number of solitary confinements was thus the lowest since the incident reporting was introduced by the Director of Public Prosecutions in 2001.

On this basis the Ombudsman concluded the case. However, he did ask the Ministry of Justice to notify him in the future of the Director of Public Prosecution's report to the Ministry on the use of solitary confinement.

On the basis of media coverage, on 30 March 2011 the Ombudsman asked the Region of Southern Denmark to inform him of the Region's investigation of a case in which two staff members from one of the Region's social residences on 8 February 2011 had taken a mentally retarded resident on a drive into a woodland area to have a "man-to-man talk" about rules. The Region informed the Ombudsman that it could rightfully be questioned whether treatment excursions of this character were ethically and legally acceptable, as the resident could have felt himself to be under undue pressure. Consequently, the social residence would be working on implementing other methods for handling citizens with behavioural problems, such as the resident in question. On 24 March 2011 the Region carried out an unannounced inspection of the social residence. The Ombudsman subsequently concluded the case.

Through visits to several psychiatric wards for children and juveniles, the Ombudsman noticed a number of problems concerning the legal basis pursuant to section 19a of the Psychiatric Act concerning searches of the patients' rooms and persons and the confiscation of private possessions. On 20 September 2011 the Ombudsman therefore asked the Ministry of Health (formerly the Ministry for Interior and Health) and the Ministry of Justice for a statement on the conflict between section 19a of the Psychiatry Act and section 72 of the Constitution (whereby, according to the latter, house searches and confiscation of property requires a court warrant unless otherwise stated by law) and the conflict between section 19a and the Coercive Measures Act. In addition, the Ombudsman asked the authorities to clarify whether measures pursuant to section 19a could be made with the patient's consent which would mean that the stipulation of an actual and probable suspicion could not be required to be fulfilled. The two ministries have presented their statements in the case which was still pending when this report was submitted.

4. Deaths, including suicide, and attempted suicide in Prison and Probation Service institutions

4.1. In general

In accordance with an agreement with the Department of Prison and Probation Service, the Ombudsman is notified of all incidents reported pursuant to the Department's departmental notice No. 146 of 14 December 2006 on incident reporting to the Department of Prison and Probation Service regarding inmates in the Service's institutions who die or expose themselves to life-threatening situations. In practice, the Ombudsman is notified of such incidents a few days after they have occurred. Subsequently, the affected Prison and Probation Service institution will investigate the circumstances surrounding the incident and send a detailed report to the Department of Prison and Probation Service which then make a decision in the case. The Department sends its decision and the documents in the case to the Ombudsman who reviews the case. A new departmental notice – departmental notice No. 84 of 23 November 2012 on the institutions' processing and reporting of incidents involving deaths, suicide, attempted suicide and other suicidal or self-harming behaviour among inmates in the care of the Prison and Probation Service − comes into force on 1 January 2013.

With effect from 25 February 2011 the Ombudsman decided that all cases involving deaths, including suicide, and attempted suicide in the institutions of the Service should be processed by the Ombudsman unit in charge of the work pursuant to the UN protocol against torture and degrading treatment. Previously, the Ombudsman's inspection division had processed these cases.

4.2. The cases

In 2011 the Ombudsman opened 48 cases on deaths, including suicides, and attempted suicide in the institutions of the Prison and Probation Service. In 2011 the Ombudsman concluded 45 cases on incidents occurring in 2011 and 2010.

The majority of the cases were concluded on the basis of the Ombudsman's review of decisions and case documents from the Department of Prisons and Probation. In some cases the Ombudsman asked the Department for more information and then concluded the cases. The Ombudsman concluded one case with criticism and recommendations.

The case in which the Ombudsman expressed criticism and gave recommendations concerned a death in a local prison in 2010. The problem was that the deceased had used medication and that he had told the local prison doctor that he bought medication from the other inmates. The local prison said to the Department of Prisons and Probation that the doctor's duty of confidentiality did, as a general rule, prevent the doctor from disclosing information about the purchase by inmates of medication in the local prison. During processing of the case it was revealed that the local prison doctor had actually passed on the information to the prison's management and staff about the deceased's purchase of medication from fellow inmates.

The Ombudsman found the local prison's conception of the law to be incorrect. In the Ombudsman's opinion disclosure in such circumstances was possible without the inmate's consent pursuant to section 43(2)(ii) and (iii). The doctor's disclosure of information would therefore not give the Ombudsman grounds for criticism. Also the Department was of the opinion that the disclosure of the information was justified but referred to section 26(2)(ii) of the Health Act. The Ombudsman stated that the Department's reference was in-

correct, as the said section 26 was part of the repealed act on the legal position of patients which with effect from 1 January 2007 had been superseded by section 43 in the new Health Act. In the Ombudsman's opinion the Department of Prisons and Probation should, to keep the record straight, inform the local prison of the correct legal basis and consider sending a general briefing to the Department's institutions to the effect that the issue of health staff's duty of confidentiality was now governed by the Health Act.

In addition, the Ombudsman agreed with the Department of Prisons and Probation in finding it regrettable that the doctor's information on the deceased's purchase of medication from fellow inmates did not cause the local prison to carry out a search immediately after the information was passed on, and that no notes had been taken regarding the disclosure of the information. Finally, the Ombudsman agreed with the Department that the Department should have followed up on the question of disclosure of information to the local prison management and staff.

Subsequently, the Department of Prisons and Probation instructed the local prison in the correct legal basis for the doctor's disclosure of information and informed the Prison and Probation Service institutions that the duty of confidentiality by health staff was governed by the Health Act, and of the Ombudsman's statement in the case.

5. Meetings with national authorities

On 11 November 2011 the Ombudsman held a meeting with the Department of Prisons and Probation concerning his OPCAT visits and other activities pursuant to the UN protocol. DIGNITY also participated in the meeting. On the basis of this meeting the Department sent the Ombudsman various documents concerning, i.a., deaths, suicide and attempted suicide among the inmates of the Prison and Probation Service institutions in 2010; a memo on health services in local and state prisons; lists of the average occupancy rate of juveniles under the age of 18 in local and state prisons; and lists of newly imprisoned persons in local and state prisons who were under the age of 18 at the time of imprisonment. It was agreed at the meeting that the Department and the Ombudsman would have a corresponding meeting annually to dis-

cuss the efforts within the field. DIGNITY and DIHR will also be invited to participate in the meetings.

Through visits to socioeducational residences the Ombudsman was informed that certain residential institutions used various control measures, such as asking the juveniles to provide urine samples or in certain instances restricting the juveniles' use of and access to i.a. mobile phones, computers and/or the internet. On 23 October 2012 the Ombudsman held a meeting with the Ministry of Social Affairs and Integration at which various fundamental issues associated with the use of these control measures were discussed. The fundamental issues concerned, i.a., the statutory authority to use the various control measures. Also discussed at the meeting was the relationship between section 123a of the Social Services Act and section 72 of the Constitution (according to which house searches and confiscation requires a court order unless otherwise stated by law) and between section 123a of the Social Services Act and the Coercive Measures Act. The Ministry of Social Affairs and Integration would report back to the Ombudsman on the basis of the meeting. Thus, the case was still pending when this report was submitted.

6. International activities

Staff from the Ombudsman's office participated in a series of European Council seminars intended to strengthen the member states' work in preventing torture and cruel, inhuman and degrading treatment. The staff participated in seminars on 14-15 March 2011 in Paris, France; on 14-16 June 2011 in Tallinn, Estonia; and on 13-14 October 2011 in Yerevan, Armenia. The topic of the seminars were mainly safety and dignity in places where people are deprived of their liberty; how information about (the risk of) degrading treatment in places where people are deprived of their liberty is collected and checked; medical conditions; and planning strategies for visits.

On 13-14 September 2011 a member of the Ombudsman's staff attended a seminar in Warsaw, Poland, organised by the International Ombudsman Institute, European Chapter. The subject of the seminar was ombudsmen and the voluntary protocol to the UN convention against torture and other cruel, inhuman and degrading treatment or punishment.

In addition, a staff member attended meetings on 6-7 December 2011 in Ljubljana, Slovenia, for, respectively, the leaders and contact persons for the national preventive mechanisms (on Day 1) and the contact persons for the mechanisms (on Day 2). These meetings were also conducted under the aegis of the Council of Europe.

7. Inspections pursuant to section 18 of the Ombudsman Act

In 2011 the Ombudsman carried out inspections in 23 institutions, pursuant to section 18 of the Ombudsman Act. Persons had been deprived of their liberty in 17 of the 23 institutions**.** Details on the inspections may be found, in Danish, on the Ombudsman's website, www.ombudsmanden.dk, under 'Om/ombudsmandens arbejde/tilsynsbesøg'. The inspections did in several cases give grounds for criticism and/or recommendations but did not reveal any conditions covered by the term "torture and other cruel, inhuman or degrading treatment or punishment".

8. Focus areas

The purpose of the Ombudsman's OPCAT visits is particularly to prevent torture and other degrading treatment or punishment in places where there are or can be persons deprived of their liberty. This means that the Ombudsman must be especially focused during the visits on i.a. general conditions which may develop in such a way that the institution's users are treated in a degrading manner. Examples may be delays in being allowed to go to the lavatory, no examination of residents' injuries, and long-term mechanical restraints. It is not, however, in the Ombudsman's brief to look at all conditions in the institutions he visits as part of the UN protocol.

As national preventive mechanism the Ombudsman has chosen to concentrate on a number of areas which are considered especially relevant to the conduct of this particular monitoring task. The choice of focus areas for the visits is i.a. based on the content of the reports on Denmark to the European Committee for the Prevention of Torture, etc., and the UN Committee against Torture and on the knowledge which the Ombudsman, DIGNITY and DIHR

already possess on the conditions for persons in Denmark who are deprived of their liberty.

The UN Subcommittee for the Prevention of Torture has carried out inspections since 2009. Relevant results from these inspections are included in the basis for the selection of areas which the Ombudsman will concentrate on in his role as national preventive mechanism.

8.1. Relationship between staff and persons deprived of liberty

The relationship between the persons deprived of their liberty and the staff who treat and guard them is of crucial importance. This is true for prison inmates, psychiatric centre patients, children and juveniles in secure residential institutions, nursing home patients with dementia or foreign nationals in asylum centres, and is therefore an important focus area for the visits. Consequently, attention will be directed towards information on, for instance, the manner of communications between staff and users, staff ratios, staff training and educational background, management guidance and monitoring of appropriate approach on the part of the staff ("right values"), and the way in which the staff carry out the care task.

8.2. Health issues

Whether or not persons deprived of their liberty and other institutionalised persons are treated with dignity, humanely and without torture is an assessment which is dependent on, i.a., the institution offering healthy living conditions and good access to medical care and other health care services. Basically, persons deprived of their liberty shall as a minimum have the same access to medical treatment as other citizens (the principle of medical equivalence). Added to this, the deprivation of liberty or the cause of the institutionalisation may, subject to circumstances, produce health problems which may only be resolved by medical expertise.

Furthermore, a recurring problem is that persons deprived of their liberty are often already ill or otherwise vulnerable, and a continued and comprehensive treatment of them is vital. Finally, it is of course particularly important to keep an eye on persons deprived of their liberty or subjected to other forms of coercion and use of force, to ensure that they are treated with sufficient respect.

There is therefore a basis for focusing on the following subjects:

- Health care services in the institution
- Health and illness among the persons deprived of their liberty
- Conditions which may influence health and cause illness among the persons deprived of their liberty

Health care services

A key point is whether *access to the health care system* is as easy as outside the institution. When examining access to the health care system in for instance prisons, the access procedure is very important, meaning whether the inmates can apply directly to a nurse or whether they have to fill in a request form and give it to the a prison officer who will then pass it on to the health care staff. In addition, the users' own experience with the access is a significant source of understanding the system. For patients on a psychiatric ward, access to somatic treatment is important, and in other situations the access to consultations in or outside the institution, for instance with own general practitioner, is significant.

Correspondingly, the *quality of the health service* is an important factor. Here the focus is on i.a. the staffing of doctors, nurses, etc. with regards to hours in relation to number of users, and whether the health staff have the qualifications expected in the general healthcare system. It is of great importance which forms of treatment are available in the institution and which treatments require a referral to the general health care system outside the institution. This is of special significance because for instance logistics and security may necessitate separate arrangements in order to implement treatment outside the institution, which may in turn mean delays and, indirectly as a result thereof, restrictions in access.

Access to health services outside business hours is important. Most often, however, the need for medical assistance outside regular working hours will be met by calling the emergency medical service, just as outside the institution.

Structurally, *the professional independence of the health care service* is essential if it is to provide independent service to persons deprived of their liberty. Doctors working as employees in the institution in which the deprivation of

liberty is taking place may face dilemmas where the interests of the patient and the interests of the institution are not necessarily identical. These dilemmas may for instance be based on considerations of security. It is therefore essential to examine the role of the health care service in procedures involving for instance solitary confinement, use of restraints and documentation of violence.

When an institution employs a doctor, the users will often not be in a position to choose their own doctor. This is the case in for instance the institutions of the Prison and Probation Service where the inmates of local and state prisons normally have to use the institution's doctor. In these instances, the incarcerated person is to a higher degree dependent on being able to establish a good rapport with the institution's doctor. If for various reasons a central disagreement between the patients and the doctor should occur, it is important to examine whether it is possible – as it is outside the institution – to consult another doctor (to get a second opinion).

Health and illness among persons deprived of liberty

An obvious requirement for a disease or other conditions requiring treatment actually being treated is that such conditions are discovered when the user arrives at the institution and not until later on. It is therefore crucial that the procedures used by the health care service on arrival of the user ensure that important conditions requiring treatment are identified and that on-going treatment already in place is stated so that it will continue. Likewise, when the user leaves the institution (is for instance released, discharged or moved) it must be ensured that the on-going treatment continues and that information thereof is passed on to the "receiving" treatment body (*treatment continuity*). However, pursuant to legislation the patient's/inmate's permission is necessary beforehand for both participation in certain medical examination procedures and for the exchange of confidential medical information.

In many instances it will be relevant to examine whether or not the person deprived of liberty is placed in the right sort of institution. For instance, mentally sick persons do not normally belong in a prison but in a psychiatric ward.

There is an increased risk in prisons and other institutions for incarcerated persons of contagious diseases, such as i.a. tuberculosis, hepatitis and HIV.

This is partly because the incarcerated persons are part of a selected group which may have a higher incidence of disease than the average population and partly because there is higher risk of infection than in society at large in institutions where many people are living under the same roof. Consequently, the state of illness and health in the institution should be monitored, for instance through an illness and health information system to indicate any necessary preventive measures.

Basic living conditions in the institution are very important. The health care service must therefore keep an eye on hygienic and sanitary conditions and report on any problems in these areas. Accordingly, it is important to ensure that such preventive monitoring mechanisms are working appropriately and prevent the exposure of the incarcerated persons to the risks of illness and adverse health conditions.

Conditions affecting illness and general health

Besides the considerations mentioned above, the living conditions and treatment provided in institutions in which persons are or may be deprived of liberty are of great consequence for illness and general health. This is true with regard to i.a. the institution's psychological environment which is dependent on safety, violence, threats, the use of solitary confinement, the use of force and disciplinary measures, access to family contact and to education and meaningful work or other activities. These factors may all influence welfare and health.

Such conditions may have an especially high impact on special needs groups ("vulnerable groups"). An inmate with a mental illness such an anxiety disorder may be at an extra high risk of suffering health damage due to solitary confinement, the use of force and threats and violence from other inmates. It is also important to be aware of problems due to gender or ethnicity. In order to prevent degrading or inhuman treatment of especially vulnerable and special needs persons deprived of their liberty it is important that they are actually identified and that special protection for these groups are implemented. The establishment of appropriate programmes for certain groups to accommodate the special needs of the group should be considered.

Methods of investigation

Health conditions may be examined using the same methods as for other conditions. The institution may be requested to *send various materials* prior to the visit, such as procedures, statistics or selected case documents. *Interviews* with the institution's management and health staff are carried out where the focus may be on referral procedures, facilities, internal and external cooperation and health issues which are not covered. The visiting team *inspects* the available facilities (for instance treatment facilities, record storage, drugs storage, solitary confinement rooms and mechanical restraints) and carries out interviews with those users who asks for or consents to interviews. These interviews may focus on how the users have experienced the institutions' handling of health issues and thereby provide valuable contributions to the assessment of health care services and the appropriateness of existing procedures. And, finally, it may be relevant to have interviews with the users' relatives.

Which specific conditions that are of relevance to the individual visit depend on the type of institution being visited. Obviously, health service conditions included in the visits must be different in a prison from those in a psychiatric centre.

8.3. Solitary confinement

Many studies show that individuals who are not only restricted in their freedom of movement but in addition are isolated from contact with other people are particularly at risk. Experience shows that the sensitivity of a person to the effects of solitary confinement varies greatly. However, in general most people are mentally very severely affected by exposure to solitary confinement, even for shorter periods of time, and the use of solitary confinement has therefore been selected as a focus of interest. During the visits the focus will be on the number of persons who are placed in solitary confinement, the extent and conditions of the isolation of the individual from others and any negative effects from too lengthy or restrictively imposed solitary confinement.

8.4. Use of force

The use of force may be necessary in order for the initial act of depriving a person of liberty to be effected but it may also be difficult to avoid it completely as part of maintaining the deprivation of liberty or in connection with treatment

of the individual in question. There are also in this instance large differences in the various types of institutions with regard to when and how force may be used. Regardless of the cause there is always the risk that the use of force may deteriorate into a violation of the ban on torture, etc. Consequently, the use of force has been targeted as a special focus area in connection with the visits.

9. Working method

Visits to places where persons are and may be deprived of their liberty are the central instrument in the work pursuant to the UN protocol. Accordingly, the Ombudsman activities are based on such visits.

According to the UN protocol, prevention of torture, etc. requires “education and a combination of various legislative, administrative, judicial and other measures”, and it is emphasised that the protection against torture “can be strengthened by non-judicial means of a preventive nature, based on regular visits to places of detention”.

In Denmark the visiting team usually consists of two legal experts from the Ombudsman office and a doctor from DIGNITY. In some cases representatives from DIHR will also take part in a visit. The Ombudsman decides, together with DIGNITY and DIHR, which institutions to visit.

In 2011 – as in 2010 − the Ombudsman chose to focus the main part of the visits on specific types of institutions. Thus, 49 out of 55 visits in 2011 were divided between 3 institution types (10 psychiatric wards, 15 branches in socioeducational accommodation facilities, 22 branches in secure residential facilities and 1 follow-up visit to a secure residential facility).

When the visiting teams see several institutions of the same type, they gain a good insight into the individual institutions within the same type. The visiting teams may for instance share this information with the institutions and include it in the discussions at the institutions. Through this process the visiting team may also learn whether a practice is prevalent in that particular field or whether it is a special feature of the individual institution. At the same time it is im-

portant to maintain that it is valuable to the visiting teams to see various types of institution, as information may in this way be combined across the institution types. The visiting team may for instance compare information about staff approach to the use of force in social institutions to that in psychiatric wards.

The Ombudsman will normally give advance notice of his visit to the institution and the supervisory authority. The advantage of giving advance notice is that the visiting team may obtain information from the institution before the visit and that the relevant persons are present in the institution on the day of visit. In 2011 advance notice were given for all but 5 visits.

Prior to the visit the Ombudsman asks the institution in question for a range of information. The purpose of this is to ensure that the visiting team are informed about the institution's practices, including for instance the institution's use of force. This means that the visiting team are better able to focus on those conditions that are especially relevant to the individual institution.

Besides asking the institutions visited by the Ombudsman in 2011 for information of a factual nature, the Ombudsman decided that he would, prior to the visits, also ask the institutions for a brief report (max 2 pages in total) on the following questions

- What preventive measures does the institution have in place to ensure that the users do not end up in inhuman or degrading situations
- What major problematic episodes has the institution experienced within the last 12 months
- Which professional (not economic) main challenges has the institution faced in 2011
- How is the residents' access to medical treatment organised

There were several reasons why the Ombudsman asked the institutions for such a report. First and foremost, the report would help the individual visiting team to target its questions more precisely during the visit, as it would prior to the visit have been apprised of i.a. significant problematic episodes and would therefore be in a position to ask more detailed questions about such episodes. In addition, the report could save time during the actual visit in those instances where the report gave satisfactory answers to matters where the visiting

team would normally ask questions. The Ombudsman has subsequently made the report part of his regular procedure when preparing a visit.

During a visiting year the Ombudsman will basically ask for the same information from equivalent institutions but it is also clear that changes may be made, just as there may be special conditions to be elucidated at specific institutions or institution types.

For instance statistical information is gathered in connection with the visits, and the visiting team may go through files and ask for copies of specific case documents. Various reports and information on the institutions' websites are also included. In addition, the attention is directed towards the legal framework for the treatment of those deprived of liberty.

Dialogue plays a large part in the visits.

A visit is thus normally begun with a meeting with the management. Discussion at the meeting is typically based on the focus areas and the material which the visiting team has received prior to the visit. For instance the use of force will normally be discussed. Specific episodes at the institution may also be discussed.

During the visit the visiting team will, apart from the management, usually also have talks with the staff and the users and often also with healthcare staff, user representatives and relatives. The team takes care that consent is obtained from i.a. the residents if information from the talks is to be imparted to the management.

The visiting team will also make a tour of parts of the institution. The tour will provide the team with an impression of the institution's atmosphere and daily routine. During the tour the team will often ask additional questions and also frequently talk with for instance staff members and residents whom the team encounters.

The information and experience thus gained by the visiting team will be used in several ways, together with team's observations.

First and foremost, the visiting team will convey relevant information to the institution's management at the concluding meeting. This may be for instance specific complaints or wishes from the users. The visiting team will also give the management a verbal and first impression of the visit and the team's on-site reflections. The meeting may also include discussion of more general problems, such as cooperation between the institution and other sectors, for instance with the municipality, police and mental health services.

The information may also be used as a basis for suggestions, recommendations or other comments to the institution and the responsible authorities.

Most comments will be given verbally at the concluding meeting. If the responsible authorities agree with the comments and state that the recommendations will be followed, these will usually not be mentioned in the concluding letter on the visit. At the concluding meeting the visiting team may also just mention matters which the team has noticed during the visit, such as the way in which the authorities register episodes of violence and issued threats.

In some instances the Ombudsman will consider making suggestions, recommendations or other written comments to the authorities. In these cases the Ombudsman will ask the authorities for a written statement before deciding whether he has grounds for making such suggestions, recommendations or other written comments.

The visits allow the visiting teams to become aware of problem areas which may be addressed in connection with subsequent, new visits, such as new visits to other institutions or follow-up visits to the same institution.

In those cases where the Ombudsman does not find grounds for making written comments to the responsible authorities, the Ombudsman will close the visit with a brief letter to the institution. The letter will contain a description of the visit and the Ombudsman's assessment of the conditions found.

Apart from visits, other methods are also be used in order to investigate and prevent torture, etc. The Ombudsman may for instance investigate cases on his own initiative and ask for information, statements and case documents. This right may be combined with visits. Information which the Ombudsman

receives as part of one or more visits may for instance prompt the Ombudsman to raise a case on his own initiative or to have a meeting with the relevant authority. The Ombudsman may also choose to raise a case on his own initiative on the basis of media coverage.

10. Legal basis for and organisation of OPCAT visits

On 19 May 2004 the Danish parliament, the Folketinget, adopted the ratification of the optional protocol to the UN Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment. This UN protocol directs the Member States to establish a system of regular visits by independent bodies to places where people are deprived of their liberty, in order to prevent torture, etc. Each of the Member States is obligated to establish one or more national authorities for the prevention of torture, etc.: the national preventive mechanism.

In the autumn of 2007 the Danish government appointed the Parliamentary Ombudsman as the Danish national preventive mechanism.

The task of the national preventive mechanism is described in more detail in article 19 of the protocol. The main task is to carry out regular visits to places where persons are deprived of their liberty, in order to strengthen the protection against and prevention of torture and other degrading and inhuman treatment. In addition, the national preventive mechanism shall make recommendations to the relevant authorities with a view to improving the treatment of and conditions for persons deprived of their liberty. Finally, the national preventive mechanism shall make suggestions and comments on existing or proposed legislation.

Both the visits and the other part of the work are presumed to have a special preventive aim with a particular duty to pay attention to general conditions bearing on whether or not there is a possible future risk of torture or other degrading and inhuman treatment.

In article 4.1., the UN protocol states that the visits shall be focused on the treatment of persons in places where they are or may be deprived of their lib-

erty. Article 4.2. of the protocol defines 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”.

To i.a. ensure that the Parliamentary Ombudsman has the necessary legal base to carry out visits to private institutions in accordance with the mandate of the UN protocol, the Ombudsman Act was amended in act No. 502 of 12 June 2009. The amendment in this regard meant that section 7(1) of the Ombudsman Act now reads: “The Ombudsman’s jurisdiction shall extend to all parts of the public administration. The Ombudsman’s jurisdiction also extends to conditions for persons deprived of their liberty in private institutions, etc. where deprivation of liberty has been effected, either pursuant to a decision by a public authority, on the request of a public authority, or with the consent or agreement of a public authority.”

These institutions have a duty to provide information, hand over documents and give written statements to the Ombudsman, pursuant to section 19(1) and (2) of the Act. In act No. 502 of 12 June 2009, section 19(5) was inserted with the following wording: “The Parliamentary Ombudsman may at any time, if it is deemed necessary, with proper authorisation and without a warrant, have access to inspect private institutions, etc. where persons are or may be deprived of their liberty, cf. section 7(1)(ii). If necessary, the police will assist in the implementation thereof.” Section 19(5) was given a new wording by act No. 568 of 18 June 2012.

The Danish Parliament allocated funds to the Ombudsman for the conduct of his task as national preventive mechanism. Parliament also presupposed that DIGNITY and DIHR would be able to make available persons with a particular medical and human rights expertise to assist the Ombudsman in his work as national preventive mechanism. From 2009 the Ombudsman’s budget was increased by approximately 2 million DKK, corresponding to 2.5 man-years, so that his office could carry out this new task. DIHR did not receive a grant from the State in 2011 for participating in the visits, while DIGNITY could receive up to 400,000 DKK for making their medical expertise available for the visits. The centre’s funds are allocated from the budget of the Ministry of Foreign Affairs. In 2011 DIHR has prioritised its participation in the council (please see below).

It is, as previously stated, the Parliamentary Ombudsman who has the authority as national preventive mechanism while DIGNITY and DIHR act as advisers to the Ombudsman. However, the Ombudsman has stated that he will let the expert advice from the two organisations carry a decisive weight, and that he will let any divergent views be reflected in the case reports, if the institutions should so wish.

The management from the three institutions meet a few times a year to discuss and plan the overall guidelines for the work. This part of the cooperation is called *the council*.

Each of the three institutions has appointed specific staff officers who participate in the running process of carrying out visits, preparing visit reports and statements about new legislation. The office of the Parliamentary Ombudsman acts as secretariat and has the overall responsibility of organising these activities. This part of the cooperation is called *the working group*.

11. Assessment basis

11.1. International legal basis

According to article 19 of the protocol the national preventive mechanism may put forward recommendations to the relevant authorities with a view to improving the treatment of and conditions for persons deprived of their liberty and to prevent torture and cruel, inhuman and degrading treatment or punishment, taking into consideration the relevant standards of the United Nations. These may for instance be:

- Relevant UN conventions (”hard law”), concerning torture and inhuman treatment, including in particular UN’s Convention against Torture, the UN Covenant on Civil and Political Rights, the UN Convention on the Rights of Persons with Disabilities, and the UN Convention on the Rights of the Child, the European Convention on Human Rights and the practice of the the European Court of Human Rights
- Relevant UN declarations, resolutions and principles (“soft law”), including in particular The Standard Minimum Rules for the Treatment of Prisoners (1997), The Body of Principles for the Protection of All Persons under Any

Form of Detention or Imprisonment (1988), United Nations Rules for the Protection of Juveniles deprived of their Liberty (1990), Code of Conduct for Law Enforcement Officials (1979) and Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and inhuman and degrading Treatment or Punishment

- Relevant practice from bodies monitoring human rights, including in particular the UN Human Rights Council, the UN Committee against Torture and the UN Subcommittee on Prevention of Torture, etc.; see for instance "The approach of the Subcommittee on Prevention of Torture to the concept of prevention of torture and other cruel, inhuman or degrading treatment or punishment under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" (2010).

In addition, Danish regulations and Danish case law is included, together with the 2006 prison regulations from the Council of Europe and the practice of the European Committee on the Prevention of Torture, etc.

Furthermore, a number of international human rights organisations have compiled guidelines and manuals for prison visits. Among others, the Association for the Prevention of Torture has written a detailed manual for the visiting task, "Monitoring places of detention" and "Implementation Manual", on the basis of the UN protocol.

It naturally follows that the conventions and the international courts' practice, particularly that of the European Court of Human Rights, on the interpretation and fulfilment of the conventions play a special role in the assessment of the conditions that the Ombudsman investigates as national preventive mechanism.

11.2. Citizens deprived of liberty

The supervision is aimed at the treatment of persons who have been deprived of their liberty by order of a public authority. As mentioned before, article 4.2 of the UN protocol defines the concept "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". In the organisation of the task the Ombudsman has taken as his basis that article 4.2 does not solely refer to persons who have been deprived of their liberty in the sense of article 5 of the European Human Rights Convention but also to persons who are actually restricted in their freedom of movement due to limited mobility.

The Ombudsman is thus competent vis-à-vis institutions where persons are being placed through a direct decision made by a public authority or where such a placement occurs with the consent or acceptance of a public authority. Such participation or acceptance is certainly present when a public authority makes a direct decision to place a person in a private institution, when public authorities pay for a stay which has been decided by private parties, and in situations where private parties make a decision to place a person in a private institution which has been approved by public authorities for such a stay.

The deprivation of liberty requirement shall be interpreted in a broad sense, both as a strictly legal deprivation of liberty and as practical restriction of the subject's freedom to choose his or her own place of residence. The provision includes the placement of children or juveniles in private institutions or boarding schools pursuant to the Social Services Act, either compulsory or with parental consent. Also the placement of the elderly in nursing homes or the mentally disabled in private accommodation facilities may constitute deprivation of liberty, either because the placement actually is compulsory pursuant to section 129 in the Social Services Act, or because the people so placed may be subject to compulsory measures pursuant to sections 124-128 of the Social Services Act.

The protocol's explanatory notes show that the physically disabled may also be protected by the protocol. Consequently, the Ombudsman's visits include private accommodation facilities, institutions, schools, social care facilities, hospitals, nursing homes, etc. which deal with the care of weakened persons who really have nowhere else to stay. It is, however, stipulated as a condition that a public authority has made a decision to place the person at the facility or has otherwise contributed to the placement.

11.3. The torture concept

Article 1 of the UN Convention against Torture defines torture as follows:

> ”For the purposes of this Convention, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.
>
> 2. This article is without prejudice to any international instrument or national legislation which does or may contain provisions of wider application.”

Section 157a(2) of the Danish Penal Code contains the following definition of torture:

> ”The contravention is considered to have been committed through the use of torture if it has been committed in the execution of a Danish, foreign or international public service or task by infliction on another person of harm to body or health or severe physical or mental pain or suffering
> 1) for the purpose of obtaining information or confessions from someone,
> 2) to punish, frighten or force somebody to do, tolerate or not do something or
> 3) due to a person’s political conviction, gender, race, skin colour, national or ethnic origin, faith or sexual orientation.”

It follows from this definition that attention must be especially focused on information about the detainees’ health, medical treatment, organisation of medical care, the use of force, and violence or other physical injury. As discrimination is included in the definition of torture, attention also be must particularly focused on groups which are especially vulnerable to discrimination,

in order to ensure that they are not and do not risk being treated in a way which violates the ban on torture, etc.

11.4. Cruel, inhuman and degrading treatment

The UN protocol also includes the prevention of cruel, inhuman and degrading treatment.

In the practice of the European Court of Human Rights on the interpretation of the corresponding provision in Article 3 of the European Human Rights Convention these terms cover a broad spectrum of conditions. The European Court of Human Rights has defined “inhuman” treatment as “severe physical or mental suffering”. The Court has in particular attempted to define and clarify the meaning of the term degrading treatment. In assessing whether treatment is degrading, the Court has emphasised whether or not the treatment caused or could cause a feeling of fear, anxiety or inferiority that was suited to humiliate or break down the victim.

The public nature of the treatment is relevant when assessing whether the treatment is degrading but a non-public nature does not mean that the treatment cannot be degrading. It may be sufficient if a person in his or her own opinion has been humiliated.

This question has generated quite a number of judgments from the European Court of Human rights. The decisions are very much influenced by the concrete circumstances in the individual cases but some general trends may be deduced from the practice.

The Court takes as its basis that poor treatment of citizens must be of a sufficiently severe character to constitute a violation of Article 3. The treatment must go beyond the element of suffering and humiliation which may often be an unavoidable consequence of lawful treatment, coercion and punishment.

When making the concrete assessment of whether or not a strain is disproportionate, emphasis is put on the intention with the treatment, and its physical and mental effect on the person. Actions which may generally be perceived to induce fear, anxiety or a feeling of inferiority in persons deprived of

their liberty are basically unacceptable, just as measures with no other purpose than to inflict pain, suffering or debasement are unacceptable.

Lawful use of force is not in violation of Article 3 but the use of force is only allowed when it is absolutely necessary, and it must not be excessive.

The acceptance of rough treatment is closely connected to the fact that the citizens have been deprived of their liberty as part of a lawful exercise of authority. The assessment of the way the citizens are treated will probably not be influenced by the mere fact that a deprivation of liberty is eventually judged to be unlawful. It must on the other hand be assumed that the nature of the assessment will change if the deprivation of liberty is clearly or grossly illegal, for instance when a person has been deprived of liberty in an institution where deprivation of liberty is not allowed at all or when a deprivation of liberty is effected quite arbitrarily or as a private act of revenge.

Furthermore, the duration of the detention is of great importance. The longer the duration, the better treatment is required, and it is vice-versa accepted in the case of very short-term detentions that the detainees are exposed to even very unpleasant conditions. Violation is held in very few cases involving short-term detention.

The accommodation offered to the detainees may be very cramped, even when the detention is of a long duration. However, regardless of the duration of the detention consideration must always be shown if the detainee is particularly vulnerable, either because s/he suffers from a serious somatic or mental illness, is in a weakened health condition or is very young or elderly. Whether the detainee is a man or a woman also plays a role and requires a certain consideration.

In practice, there is no hard and fast boundary between behaviour violating Article 3 of the European Human Rights Convention and actions which are in Danish eyes unacceptable because they indicate a lack of consideration or respect. No sharp distinction is made between these different categories in connection with the monitoring visits, among other things because the supervision has both a reactive and a proactive aim.

11.5. The rights of those deprived of liberty

Basically, persons deprived of liberty have the same rights as all other citizens, with the exception, however, that their personal freedom is restricted. They thus preserve all the rights which have not been taken from them legally through the decision by which they have been deprived of their liberty.

The leading human rights principle, that everyone must be treated with respect for his or her integrity and dignity, also applies to persons deprived of their liberty. Translated into practice, this means that the detainee must have access to reasonable accommodation, sleep, food and drink, personal hygiene and a lavatory. In addition, the detainee is entitled to maintaining contact with the outside world as far as possible, including regular contact with family and other persons by letter, telephone and visits. Furthermore, detainees are entitled to external legal assistance and medical and other health-related assistance for the treatment of illnesses and injuries.

When force has been used a medical inspection is necessary if illness or injury is suspected or if the detainee asks for medical attention. Bruises and wounds that have occurred after the deprivation of liberty was effected impose upon the authorities a burden of proof that they are not the result of abuse. The personnel responsible for the arrest and the surveillance have a duty to respect the detainees in both word and action. The detainee must be spoken to and of without verbal abuse but must also tolerate that, dependent on the situation, the tone may be hard, peremptory and coarser than common courtesy usually dictates.

When depriving vulnerable groups, such as women, children and foreign nationals, of their liberty, the authorities must give particular attention to the specific physical, mental, social or other needs that these groups may have.

Copenhagen, 21 December 2012