FOLKETINGETS OMBUDSMAND

OPCAT Annual Report 2012

Danish Parliamentary Ombudsman

FINAL REPORT

Doc. No. 13/04707-26/

Contents

1. The Parliamentary Ombudsman as National Preventive Mechanism in 2012

In 2012, together with DIGNITY (Danish Institute Against Torture) and DIHR (Danish Institute for Human Rights), the Parliamentary Ombudsman focused his endeavours against inhuman and degrading treatment on following up on the 2011 theme of children and juveniles, institutions for the elderly, and private institutions. Therefore, the majority of the year's monitoring visits, which is the most important instrument, went to institutions where there were or might be children, juveniles or elderly people deprived of their liberty. Most of the visited institutions were run by public authorities but the Ombudsman also visited a number of privately run institutions.

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

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

Some visits uncovered problematic issues which the Ombudsman subsequently raised with the relevant authorities.

In 2012 the Ombudsman raised some general issues concerning the rights of children and juveniles at accommodation facilities and in connection with coercive measures in psychiatry.

The case on the rights of children and juveniles at accommodation facilities prompted the Minister for Social Affairs, Children and Integration to set up a committee on the use of forcible measures at accommodation facilities for children and juveniles. The committee shall define the challenges of the use of forcible measures towards children and juveniles at residential institutions, other accommodation facilities and foster families. The committee shall also make proposals for new regulations, if relevant. The committee shall make its report before the end of 2014.

At the request of the Ombudsman, the Ministry of Social Affairs, Children and Integration instituted three amendments to the Act on Social Services concerning the use of forcible measures towards children and juveniles, as these amendments could not, said the Ministry, await the committee's report and any resulting new rules. The Ministry expected a draft bill with the three amendments to be introduced in Parliament in February 2014.

In the matter of the legal position of children and juveniles in connection with coercive measures in psychiatry, the Ministry of Health informed the Ombudsman that according to the Government's legislative programme a bill will be introduced in Parliament in February 2014 with an amendment of the Psychiatry Act, and that the Ministry of Health expected the bill to propose that the legal position of minors in connection with coercive measures appears explicitly in the Psychiatry Act, including channels of complaint, etc.

The Ombudsman's OPCAT unit, which was responsible for the Ombudsman's tasks as NPM, was in 1 November 2012 merged with the Ombudsman's Monitoring Department. The purpose was to bring together the Ombudsman's task related to monitoring visits in a new Monitoring Division. On the same day the Ombudsman opened a Children's Division which i.a. carries out monitoring visits to institutions for children and juveniles. The Ombudsman's OPCAT function is anchored in the Monitoring Division but the work of the Children's Division also includes OPCAT tasks such as, for example, monitoring visits to institutions where children and juveniles are or may be deprived of liberty.

The Ombudsman's work against inhuman and degrading treatment was executed in collaboration with DIGNITY and the Danish Institute for Human Rights (DIHR), both of which contribute to the collaboration with special medical and human rights expertise. This means among other things that personnel with this special expertise participate on behalf of the two institutions in the planning, execution and follow-up of monitoring visits.

The work against inhuman and degrading treatment was carried out 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 and Degrading Treatment or Punishment, abbreviated as OPCAT).

2. Monitoring visits during 2012

2.1. In general

The Ombudsman carried out the following OPCAT visits in 2012:

Jabes (accommodation facility)	29 February 2012
Plantagen (accommodation facility)	12 March 2012
Trongården (nursing home)	14 March 2012
Solhaven (accommodation facility for juveniles and temporary accommodation	

facility for adults)	28-29 March 2012
Christiansminde (accommodation facility)	30 March 2012
Lundtoft Plejehjem (nursing home)	18 April 2012
Distriktscenter Strandby (nursing home)	19 April 2012
Kvindecenteret (centre for female asylum seekers)	2 May 2012
Vestre Fængsel, ungeafsnit (local prison for under-age offenders)	15 May 2012
Statsfængslet i Nyborg (Nyborg State prison)	30 May 2012
Statsfængslet Østjylland (East Jutland State prison)	14-15 June 2012
Center Ebeltoft (asylum centre)	19 June 2012
Engelsborg (Prison and Probation Service half-way house)	28 June 2012
Grennessminde (accommodation facility for juveniles and temporary accommodation facility for adults)	22 August 2012
Løvstikken (residential institution)	23 August 2012
Kærbygård (temporary accommodation facility for adults)	23 August 2012
Elmelunden Plejecenter (nursing home)	11 September 2012
Elmely Plejehjemsbolig (assisted living facility for the elderly)	13 September 2012
Gerontopsykiatrisk afsnit G20, Brønderslev (gerontopsychiatric unit)	14 September 2012
Gerontopsykiatrisk afsnit 2222, Psykiatrisk Center Hillerød (gerontopsychatric unit)	24 September 2012
Statsfængslet på Søbysøgård (State prison)	27-28 September 2012
Center Sandholm, persons with tolerated stay status (asylum centre)	1 October 2012
Vestre Fængsel, block F-O (local prison)	10 October 2012
Elmehøjen (accommodation facility for juveniles and temporary accommodation facility for adults)	24 October 2012
Bernards Hus (temporary accommodation facility for adults)	25 October 2012
Egely (follow-up visit to secured residential institution)	30 October 2012
Birkebo (nursing home)	20 November 2012
Vestre Fængsel, Vestre Hospital (local prison, hospital ward)	11 December 2012

All visits, except four (the visits to Løvstikken, Elmelunden Plejecenter, Egely and Elmely Plejehjemsbolig), were carried out with medical assistance from DIGNITY. The DIHR participated in five visits (gerontopsychatric Unit 2222, Psykiatrisk Center Hillerød; Center Sandholm, persons with tolerated stay status; Egely; Vestre Fængsel, block F-O; and Vestre Fængsel, Vestre Hospital (State Prison hospital ward)).

The monitoring visits were carried out at 26 institutions (3 State Prisons, 2 psychiatric units, 6 socioeducational accommodation facilities for juveniles (of which 3 were also temporary accommodation facilities for adults), 2 temporary accommodation facilities

for adults, 6 nursing homes, a Prison and Probation Service half-way house, a local prison, a residential institution and a secure residential institution).

Twelve of the visited institutions were private institutions.

Four visits (the visits to Solhaven, Egely, Løvstikken and Kærbygård) were carried out without prior notice while the other visits were carried out with advance notice. All the visits took place in the daytime on weekdays.

The institutions were very cooperative and helpful towards the visiting teams, including those institutions which received unannounced visits.
During all the visits the monitoring teams had interviews with the management of the institutions.

The monitoring teams spoke with the users (inmates and patients) at all the institutions, except for the visits to Løvstikken (residential institution) and Engelsborg (Prison and Probation Service half-way house). At the unannounced visit to Løvstikken, there were no children on the premises for the team to speak to. The one resident, who wanted to speak with the monitoring team during the visit to Engelsborg, was not present during the visit but spoke on the telephone with a member of the monitoring team after the visit.
The monitoring teams spoke with 157 users in total in 2012.

The monitoring teams also spoke with staff at most of the institutions. At a number of institutions the teams also spoke with relatives of the users and, again at a number of institutions, with healthcare personnel. The relevant supervising authority was represented at a number of the visits.

Most visits were concluded without the Ombudsman finding grounds for making any written comments to the responsible authorities. There were grounds for comments in connection with five visits where the institutions lacked practice instructions on the management of medication (Christiansminde – see paragraph 2.5 on visits to accommodation for juveniles and temporary accommodation facilities for adults; Elmehøjen – see paragraph 2.5; Kærbygård – see paragraph 2.5; Løvstikken – see paragraph 2.6 on visits to residential institutions; and Engelsborg – see paragraph 2.9 on visit to a Prison and Probation Service half-way house). The institutions stated either during or after the visit that practice instructions on the management of medication would be prepared shortly. In the case of one monitoring visit (Solhaven (accommodation for juveniles and temporary accommodation facility for adults) − see paragraph 2.5) the

Ombudsman decided to discontinue his investigation because charges were brought in court for matters dealt with during the visit, and because the Ombudsman does not investigate complaints about matters which are being processed by the courts. Consequently, neither did the Ombudsman investigate conditions seen by the monitoring team during this visit. In connection with one visit (Distriktscenter Strandby (nursing home) – see paragraph 2.4, on visits to nursing homes) the Ombudsman instituted a detailed investigation which was still pending at the time when this report was submitted.

2.2. Theme

Following consultations with DIGNITY and DIHR, the Ombudsman decided that the themes for the 2012 OPCAT visits would be private institutions, institutions for the elderly and a follow-up on the 2011 theme of children and juveniles. This decision meant that the majority of visits in 2012 went to institutions where there were − or where there could be – children, juveniles or elderly people deprived of liberty. In addition, it was emphasised that part of the institutions visited should be privately run institutions.

The reason why the Ombudsman together with DIHR and DIGNITY focused on privately run institutions in 2012 and followed up on the 2011 theme of children and juveniles was related to the results of the 2011 OPCAT visits. Thus, in three out of eight of the Ombudsman's 2011 OPCAT visits to private socioeducational accommodation facilities conditions were uncovered which gave the Ombudsman grounds for closer investigation. Furthermore, during the visits to accommodation facilities in 2011 the Ombudsman discovered that certain accommodation facilities asked the juveniles to submit urine tests and limited the juveniles' use of and access to, among other things, mobile phones, computers and/or the Internet − measures which the Ombudsman wished to address further. This was, inter alia, done through more OPCAT visits to accommodation facilities in 2012.

The Ombudsman visited two nursing homes towards the end of 2011. These visits prompted the Ombudsman, DIGNITY and DIHR to choose to focus on, inter alia, elderly citizens who were or could be deprived of their liberty. The theme of institutions for the elderly was based on a wish to gain insight into the everyday life of elderly citizens and those problematic issues and challenges which concern these citizens. In addition, the elderly may have reduced physical and/or mental capacity, including for example dementia, and are therefore a vulnerable group with few resources.

The elderly may be deprived of their liberty for a variety of reasons and in various types of both public and private institutions. The Ombudsman, DIGNITY and DIHR chose to shed light on the 2012 theme of conditions for the elderly by visiting six nursing homes and two gerontopsychiatric units. The Ombudsman also visited a nursing home at the beginning of 2013. In addition, the Ombudsman visited the two aforementioned nursing homes at the end of 2011. The Ombudsman visited several institutions of the same type in order to gain insight in the ways the same type of institution could be run and in the ways similar institutions executed the same tasks and met the same challenges. In addition, the Ombudsman wanted – as far as possible – to visit both public and private institutions. The gerontopsychiatric units were under the public administration. Two of the nursing homes were private while the other seven nursing homes were municipal.

In 2012 the Ombudsman also visited three privately-run asylum centres under the Danish Red Cross.

In connection with the visits to private institutions, the Ombudsman used his right to investigate the conditions for those deprived of liberty at private institutions, etc. which followed from the amendment to the Danish Ombudsman Act by Act No. 502 of 12 June 2009.

In addition to the visits which followed directly from the themes of children, juveniles, the elderly and privately-run institutions, the Ombudsman visited three State Prisons, one half-way house and one local prison which were all public institutions under the Prison and Probation Service.

2.3. Visits to gerontopsychiatric units

The Ombudsman visited gerontopsychiatric Unit 2222 at the Psychiatrisk Center Nordsjælland (Psychiatric Centre North Zeeland) under the Capital Region Denmark's Mental Health Services, and gerontopsychiatric Unit G20 at Brønderlev under the North Denmark Region Mental Health Service. Unit 2222 is an open ward for people over 70 who have a mental illness and who need gerontopsychiatric treatment and support 24 hours a day. Unit G20 is a closed specialist unit for elderly patients with a complex psychiatric illness.

One of the characteristics of psychiatric institutions is that various measures of coercion may be used towards the patients, such as deprivation of liberty, compulsory treatment, forced physical restraint, and the use of physical force generally. The pa-

tients will typically stay at the institution for a longer period of time, for instance because they suffer from a serious psychiatric disorder which requires treatment.

Both visits were concluded without the Ombudsman finding any grounds for written comments to the responsible authorities.

2.4. Visits to nursing homes

The Ombudsman visited six nursing homes in 2012. Five nursing homes were municipal and one was privately run. Five of the nursing homes had both a somatic ward and a ward for users with dementia. Users with dementia could also stay in the somatic ward.

Nursing homes may use various forms of coercion, for instance restraint of a person in connection with personal hygiene situations or the use of personal alarm and paging systems. In addition, the municipality or the state administration may decide that a person shall live in a specific nursing home without that person's consent.

Four visits were concluded without the Ombudsman finding any grounds for written comments to the responsible authorities.

Concerning the visit to the Distriktscenter Strandby nursing home, the Ombudsman decided to ask the Esbjerg municipality for a statement in a matter of special exit door openers/exit door alarms at the centre. At the same time the Ombudsman asked the nursing home to send the municipality its comments on the matter for use in the municipality's statement. Except for the matter of special exit door openers/exit door alarms, the Ombudsman did not find grounds for making any written comments to the authorities responsible for the nursing home. The Ombudsman has received the municipality's statement in the case which was still pending at the time when this report was submitted.

The case concerning the visit to Elmely Plejehjemsbolig (assisted living facility for the elderly) was still pending at the time of this report's submission.

2.5. Visits to accommodation facilities for juveniles and temporary accommodation facilities for adults

The Ombudsman visited three socioeducational accommodation facilities for juveniles, cf. section 66 (v) of the Danish Act on Social Services. The Ombudsman also visited five temporary accommodation facilities for adults pursuant to section 107 of the Danish Act on Social Services. A municipality may offer temporary accommodation ac-

cording to section 107 to persons who need it because of significantly reduced physical or mental functional capacity or special social problems. Three of the temporary accommodations facilities visited were also (among other things) accommodation facilities for juveniles.

The accommodation facilities and the section 107 institutions were undertakings governed by private law.

Depending on the type of placement facility, the rules pertaining to coercive measures for children and juveniles vary. At accommodation facilities it is for example allowed that the young person is restrained or led to another room if the young person exhibits such a behaviour that allowing him or her to remain in the group would be irresponsible or if the young person is thereby prevented from self-harm or from inflicting harm on others.

Provisions on the use of force towards adults apply to persons with a substantial and permanently impaired mental function who are receiving personal and practical help and socioeducational assistance or activation and who do not consent to these measures. In the case of this specific group of persons, force may for example be used in the form of physically restraining the person or leading the person into another room when there is an imminent risk that the person may cause substantial injury to him- or herself or others, and when it is absolutely necessary in the given situation.

Two of the three visits to accommodation facilities – namely the visits to Jabes and Plantagen – were concluded without the Ombudsman finding grounds for written comments to the authorities responsible.

During the visit to the accommodation facility Christiansminde, the institution informed the Ombudsman that there were no written instructions on medicines management. Following the visit the Christiansminde, institution informed the Ombudsman over the telephone that instructions on medicines management would be prepared very shortly. The Ombudsman then concluded the case without commenting further to the authorities responsible.

Solhaven, Elmehøjen and Grennessminde were among (other things) both socioeducational accommodation facilities for children and juveniles and temporary accommodation facilities for adults.

Following the visit to Solhaven, the Ombudsman received information that the North Jutland Police had charged 12 persons, who either had been or were employed by Solhaven, for violation of, among other things, section 260 (1)(i) of the Penal Code, regarding duress. On this basis the Ombudsman decided definitively to discontinue his investigation of conditions at Solhaven. The Ombudsman emphasised that the North Jutland Police had among other things brought charges for abuse and duress and that these charges concerned coercive measures and the relationship between staff and the young people, which were the priority areas for the visit to Solhaven. In addition, the Ombudsman emphasised that the charges meant that the matter was now before the courts. The Ombudsman cannot investigate complaints about the courts and, consequently and according to practice, neither does he investigate matters or issues being tried by the courts or which are expected to be brought before the courts. The visit to Solhaven was thus concluded without the Ombudsman deciding on the conditions which were the focus of the visit. The abovementioned criminal case against staff at Solhaven was still pending at the Aalborg City Court at the time of this report's submission.

During the visit to Elmehøj, the monitoring team found that the institution had no written instructions on medicines management. Consequently, the team arranged with the institution that written instructions on medicines management would be prepared as soon as possible. The Ombudsman then concluded the visit without making any more comments to the responsible authorities.

The Ombudsman concluded his visit to Grennessminde without making any written comments to the responsible authorities.

Kærbygård and Bernards Hus were temporary accommodation facilities for adults.

The Ombudsman concluded the visit to Bernards Hus without making any written comments.

During the visit to Kærbygård, the Ombudsman's monitoring team found that the institution had no written instructions on medicines management. Consequently, the team arranged with the institution that written instructions on medicines management would be prepared as soon as possible. Following the visit, Kærbygård informed the Ombudsman that the institution now had written instructions on medicines management "according to the National Board of Social Services guidelines". In his concluding letter the Ombudsman said that the agreement made during the visit was that Kærbygård

would prepare written instructions on medicines management according to the guidelines of the Health and Medicines Authority.

The monitoring team noted among other things during the visit that there was a barrel bolt on a half-door to a room in one of the residents' flat, and following the visit Kærbygård sent the Ombudsman additional information about the use of the barrel bolt. Subsequently, the institution informed the Ombudsman over the telephone that the use of the barrel bolt had already ceased at the time of the Ombudsman's visit, that the barrel bolt had been dismantled, while the door into the room in the resident's flat was still divided in two.

The Ombudsman took no further action in the matter, as the barrel bolt had only been used for a short time and was no longer in use at the time of the Ombudsman's visit. Apart from the matter of the missing written instructions on medicines management, the Ombudsman did not receive any information necessitating any written comments to the responsible authorities. Consequently, the Ombudsman concluded the visit.

The Ombudsman will continue to focus on conditions at accommodation facilities.

2.6. Visits to residential institutions

The Ombudsman visited a municipal residential institution pursuant to section 66 (vi) of the Social Services Act, and a regional secure residential institution pursuant to section 67 (3) of the Social Services Act.

As mentioned above, the rules pertaining to the coercive measures towards children and juveniles vary depending on the type of placement facility.

In residential institutions under section 66 (vi) of the Social Services Act, forcible measures are for example allowed in the form of physically restraining a young person or leading the person into another room if he or she exhibits such behaviour as to render a continued stay with others irresponsible or if the young person is thereby prevented from self-harm or from harming others. The young person's body or room may also be searched. In addition, residential institutions may decide to lock up the ward at night or, as an exception, for limited periods of time during the day.

A secure residential institution for children and juveniles will have at least one secure ward and may have one or more specially secure wards. The outer doors and the windows of a secure ward may be locked continuously and permission may be given to lock the doors to the residents' rooms at night.

A secure ward may be used for juveniles for example when it is absolutely necessary to prevent the juvenile from self-harm or from harming others and the danger of that happening cannot be adequately prevented by other, more gentle measures; when the placement is a substitute for pre-trial detention; when the placement is the result of a sentence; or when the juvenile is an alien under 15 years of age without a requisite residence permit.

Specially secure wards may be used for juveniles when there are grounds for placement in a secure ward; when placement in a secure ward is not or will not be sufficient; and in cases involving juveniles with a mentally deviant behaviour when there is a written medical assessment that the juvenile exhibits present symptoms of a diagnosis.

In secure and specially secure wards forcible measures are for example allowed in the form of restraint, solitary confinement and search of the juvenile's person and room.

During the visit to the residential institution Løvstikken the monitoring team found that the institution's medicine cupboards were not locked and that the institution had no written instructions on medicines management. Following the visit, the institution informed the Ombudsman over the telephone that instructions on medicines management would be prepared very shortly. The Ombudsman then concluded the case without commenting further to the authorities responsible.

The visit to the secure residential institution Egely was a follow-up visit to a visit on 28 and 29 June 2011. The focus of the follow-up visit was the use of coercive measures and the administration of rules. The conclusion on the visit was still pending at the time of this report's submission.

2.7. Visits to asylum centres

The Ombudsman visited three asylum centres run by the Red Cross and therefore to be considered privately run. Of the three centres, one was Kvindecenteret (the Women's Centre) which is a special centre for single women with or without children; and one was Center Ebeltoft which is a centre for single men over the age of 18. The asylum seekers resided at the two centres while the authorities processed their applications. In addition, the Ombudsman visited those persons with a tolerated stay status, residing at the Center Sandholm asylum centre.

Pursuant to section 42 A (5) of the Danish Aliens Act, the Danish Immigration Service establishes and runs accommodation centres for asylum seekers, sometimes in collaboration with for example private organisations or municipalities. In agreement with the Immigration Service, the Danish Red Cross runs a number of accommodation centres. The Immigration Service decides where the asylum seekers should be lodged.

An alien is relegated to tolerated stay status in Denmark when he or she is either excluded from asylum according to Article 1 of the UN's Convention relating to the Status of Refugees or when he or she is expelled as a danger to national security or because of convictions for serious crime but when it would be in violation of the Denmark's international obligations to forcibly expel the person. The Immigration Service decides that an alien with tolerated stay status must reside at a specific accommodation centre unless there are special reasons against it (residence requirement). Unless there are special reasons against it, the police decide if an alien with tolerated stay status must report to the police at specific times with a view to ensuring that the police are informed of the alien's place of residence (duty to report to the police).

During the visit to Center Ebeltoft, a resident attempted suicide. The Danish Red Cross provided the Ombudsman with various details pertaining to the attempted suicide.

The visits to Kvindecenteret and Center Ebeltoft were concluded without the Ombudsman finding grounds for making any written comments to the responsible authorities.

The case concerning the visit to Center Sandholm with persons with tolerated stay status was still pending at the time of this annual report's submission.

2.8. Visits to State Prisons

The Ombudsman visited Statsfængslet i Nyborg (Nyborg State Prison) and Statsfængslet Østjylland (East Jutland State Prison) which are both closed prisons. In addition, the Ombudsman visited Statsfængslet på Søbysøgård (Søbysøgård State Prison) which is an open prison.

A closed prison is, among other things, characterised by a surrounding ring wall and/or a fence, and the presence of alarms and surveillance cameras. The doors are locked, both outer doors and the doors between units. In an open prison there are no special obstacles, and it is consequently possible to walk right out of an open prison.

The execution of a prison sentence usually takes place in an open prison. Execution of a prison sentence in a closed prison may for example take place if the sentence is for 5 years or more, if it is considered necessary in order to prevent assault on other inmates or staff, or if there are specific reasons for assuming that the convicted person presents a flight risk if he or she is placed in an open prison.

Prisons are for those inmates who have been sentenced. Some prisons also have a remand section with inmates who have not yet been sentenced.

At the Nyborg State Prison the Ombudsman visited the infirmary, the punishment and solitary confinement section and the specially secured unit. Following the visit, the prison sent the Ombudsman a report on the special measures implemented by the prison for an inmate on remand at the prison's specially secured unit. The visits were concluded without the Ombudsman making any written comments to the responsible authorities.

The cases concerning the visits to the East Jutland State Prison and the Søbysøgård State Prison had not been concluded at the time of this annual report's submission.

2.9. Visits to a Prison and Probation Service half-way house

The Ombudsman visited Engelsborg which is a Prison and Probation Service half-way house.

The Prison and Probation Service half-way houses are more open than the open prisons. The people staying there may for example be people who are under supervision by the Prison and Probation Service and convicts who are stationed there from a State Prison. Residents at a half-way house may for example serve the last part of their sentence there as part of a re-entry programme into society, and the residents often work or train outside the half-way house.

Engelsborg is a re-entry institution, and the residents may live there together with spouses/partners and children between the age of 0 and 15 years.

In connection with the Ombudsman's visit to Engelsborg it was found that the institution did not have any written instructions on medicines management. Following the visit the institution informed the Ombudsman over the telephone that instructions on medicines management would be prepared very shortly. Apart from this, the Ombudsman found no grounds for making any written comments to the responsible authorities.

2.10. Visit to a local prison

The Ombudsman visited the youth offender unit, unit F-O and Vestre Hospital (prison hospital) at Vestre Fængsel (Vestre Prison) on three separate occasions. Vestre Fængsel belongs under Copenhagen Prisons and functions primarily as a local prison for remand prisoners. However, the prison may also hold inmates who have been sentenced.

The youth offender unit is a special unit for young people. During the Ombudsman's visit the unit had two young inmates under the age of 18 while the rest of the inmates were young people between the age of 18 and 20 who had been deemed suitable for the inclusion in the youth offender group. The visit to the youth offender unit was concluded without the Ombudsman finding grounds for making any written comments to the responsible authorities.

At Vestre Fængsel, inmates in solitary confinement pursuant to court orders, excluded from associating with fellow inmates in accordance with section 63 (1) of the Corrections Act, or voluntarily excluded from associating with fellow inmates, were as a predominant rule placed in unit F-O. Consequently, this unit functioned as an isolation unit and a unit with limited association with others. The Ombudsman concluded his visit without making any written comments to the responsible authorities.

Vestre Hospital, which is a part of Vestre Fængsel, functions as an infirmary for Copenhagen Prisons. In addition, the hospital is a national prison hospital and also receives inmates from other local prisons and State Prisons for care and treatment which the inmates cannot receive elsewhere. The hospital provides for example care and treatment for somatic and mental illnesses which do not require hospitalisation at an ordinary national health service hospital. The hospital consists of two wards – VH1 and VH2. VH1 is primarily used for inmates with somatic illnesses while VH2 is mainly used for inmates with mental afflictions. The visit gave the Ombudsman grounds for visiting VH2 again on 2 May 2013. The re-visit was mainly focused on (among other things) access to activities and thereby occupation and leisure time for the inmates. The cases involving the visits to Vestre Hospital was still pending at the time of this annual report's submission.

3. Information about visits in 2011

3.1. Socioeducational measures cannot be carried out by force

During the visit to the accommodation facility Fonden Kanonen, the facility informed the monitoring team that force was used to make the young people sit on a sofa – an

educational tool which was called reflection time, a “time-out” for the young people if they would not follow the rules.

While sitting on the sofa, a young person was meant to reflect on a number of questions. The reflection time could last from a few minutes to several hours. In one instance the staff asked a young person to sit on the sofa to get him to admit that he had a mobile phone which he was not allowed to have. The young person refused to do so. The staff tried in vain to persuade the young man, and when this failed they took hold of him in order to lead him to the sofa. The young man resisted and the staff laid him down on his stomach until he agreed to sit on the sofa.

After the visit the Ombudsman started an investigation of a number of issues and asked the facility and Favrskov Municipality, the supervising authority for the facility, to comment. Among other things, the Ombudsman asked the facility and the municipality to state whether the use of a number of educational measures had been professionally assessed and whether it was a legal purpose to carry out educational measures by force. The Ombudsman also asked for an account of the system of room inspections.

During the visit the facility had informed the monitoring team that the police was in the process of investigating a rape which the staff had reported regarding a young man who had raped a young woman; both the young people were living in the same unit at the facility. The Ombudsman asked the facility to give an account of the handling of this incident.

Based on his review of the case and the statements from the facility and the municipality, the Ombudsman found that the facility’s understanding of the rules on forcible measures according to the Social Services Act was not sufficiently precise, and this implied a risk that not all uses of force were reported as stipulated by the Executive Order on forcible measures.

In addition, the Ombudsman asked the facility to consider ways in which to ensure that the staff did not impose educational measures, such as reflection time, by force.

Furthermore, the Ombudsman asked the facility to consider ways in which to ensure that the residents were informed that the facility could not force them to participate in educational activities, and that they were free to leave for example reflection time when they wanted.

With regard to the facility's educational tools, the Ombudsman was of the opinion that there was no general professional evaluation of the facility's use of the educational tools reflection time, reflection excursions and cancelling of days. The Ombudsman asked the facility to consider making a systematic review of a number of such incidents with inclusion of, among other things, the young people, the staff and external expertise with a view to evaluating the staff's use of the aforementioned educational tools.

The Ombudsman took no further action regarding the facility's room inspection measure. The Ombudsman emphasised that the facility had recognised a need to increase the knowledge of the existing rules pertaining to the search of persons and rooms; that the facility in 2012 had begun reporting searches of persons and rooms; and that the facility in dialogue with the municipality was going to design and incorporate a procedure for the search of persons and rooms.

The Ombudsman took no further action in the matter of the young man and the young woman who lived in the same unit of the facility. The Ombudsman emphasised that the facility had considered carefully the best interests of both the young people and that the Ombudsman could only criticise the facility's decision if the matter presented special circumstances, which was not the case.

The Ombudsman then concluded the case.

3.2. Pending visits

The Ombudsman visited the Politigårdens Fængsel (local prison at police headquarters in Copenhagen) with 25 cells. It has since 2004 been used as a special prison and remand centre for, e.g., negatively strong inmates who behave in a violent or threatening manner towards others.

Following the visit the Ombudsman started an investigation of the prison's decisions regarding a so-called raised security level for certain inmates and asked Politigårdens Fængsel, Copenhagen Prisons and the Department of Prison and Probation Service for a statement in the matter. The reason was that the Ombudsman, based on his visit, understood a raised security level to mean that an inmate's right to participate in activities and/or having social contacts in prison was reduced, and that inmates with an increased security level were kept in their cells for 23 hours a day.

Apart from the issue of raised security levels, the Ombudsman did not find grounds for making any written comments to the responsible authorities. The Ombudsman has

received the authorities' statements in the case, which was still pending at the time of this annual report's submission.

During the tour of the ward for eating disorders at Børne- og Ungdomspsykiatrisk Center Bispebjerg (Bispebjerg Psychiatric Center for Children and Juveniles), the Ombudsman's monitoring team witnessed an incident involving the use of force on an underage patient. 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 received the statements from the three authorities and subsequently sent the statement on to the Ministry of Health for any comments. The Ombudsman has received a reply from the Ministry in the case which was still pending at the time of this annual report's submission.

Following the visit to the residential institution Aktiv Weekend, the Ombudsman asked the institution to explain the educational expertise and background which formed the basis for a number of educational measures, and how the institution ensured that these measures were carried out in a way which did not endanger the health and security of the young people. The Ombudsman also asked for comments from Silkeborg Municipality, the supervising authority for the institution. The Ombudsman has received the requested accounts and comments. The case was still pending at the time of this annual report's submission.

4. Investigations

4.1 Search of psychiatric facility and legal position of children and juveniles in connection with coercion in psychiatry

Based on visits in 2011 to psychiatric facilities for children and juveniles, the Ombudsman focused especially on the legal position of children and juveniles in connection with coercion in psychiatry. In addition, visits in 2011 to several psychiatric treatment facilities for children and juveniles drew the Ombudsman's attention to a number of problems concerning the legal basis in section 19a of the Psychiatry Act for the search of the patients' rooms and persons by the facility staff, and for confiscation of personal effects. On 20 September 2011 the Ombudsman therefore asked the Ministry of Health (previously the Ministry of Health and Home Affairs) and the Ministry of Justice for statements on various issues concerning searches of psychiatric facilities.

The statements from the Ministry of Health and the Ministry of Justice said that in the ministries' opinion some of the measures listed in section 19a of the Psychiatry Act were covered by section 72 of the Danish Constitution (whereby house search and

seizure requires a judicial order unless otherwise warranted by statute). It also appeared that, in connection with an up-coming draft for an amendment of the Psychiatry Act, the Ministry of Health would propose that the legislative text specify that measures pursuant to section 19a of the Psychiatry Act could be carried out without a judicial order. The Ombudsman took note of the information received from the ministries.

Furthermore, it appeared from the replies that the ministries agreed that some of the measures listed in section 19a of the Psychiatry Act were also covered by the Coercive Measures Act. This meant that when deciding to carry out a coercive measure according to section 19a of the Psychiatry Act, the consultant doctor should also ensure compliance with the case processing rules of the Coercive Measures Act. The Ombudsman took note of this statement.

In its statement the Ministry of Justice set out the relationship between section 19a of the Psychiatry Act and section 9 of the Coercive Measures Act. The Ministry of Justice took into account that the suspicion requirement in section 19a (1) of the Psychiatry Act and in section 9 (1) of the Coercive Measures Act was the same. In case of a reasonable suspicion that illegal objects were or were attempted to be passed on to the patient, the issue then arose whether the consultant doctor's powers pursuant to section 19a (1) of the Psychiatry Act still applied or whether it was only the police which in such cases could carry out searches according to the rules of the Administration of Justice Act concerning criminal procedure law, cf. section 9 (1) of the Coercive Measures Act.

In the opinion of the Ministry of Justice, the consultant doctor would be able to carry out a search in accordance with section 19a of the Psychiatry Act, even when the search concerned illegal objects, if the search was done with the consent of the patient (section 9 (4) of the Coercive Measures Act), or if the search were conducted with another purpose than that of obtaining information with a view to determination of punishment (section 9 (2) of the Coercive Measures Act). This could, among other things, be the case if the purpose of the search was to prevent the patient from possessing objects which presented a danger to the patient or to others or which had a negative influence on the patient's treatment.

The Ombudsman took note of this information.

In his letter of 20 September 2011 the Ombudsman had asked whether a patient could consent to for example a search with the result that the search could be effected with-

out the condition in section 19a of the Psychiatry Act regarding “reasonable suspicion” being fulfilled.

The Ministry of Health replied that informed consent from the patient in connection with the measures listed in section 19a had the effect that the measure would not be considered to be coercive. The conditions for mounting a search according to section 19a would therefore not need to be observed. The Ministry referred to the definition of force in section 1 (2) of the Psychiatry Act and to section 4 of the Psychiatry Act which states the fundamental principle that force must never be applied before consent has been attempted.

On the basis of this reply, on 19 December 2012 the Ombudsman asked the Ministry of Health to come to a meeting for an in-depth discussion of the question of consent to searches. At the meeting the Ombudsman would also like to discuss the problem of consent in general in relation to minors, and he suggested that the following subjects be discussed:

- The legal effects of informed consent to a measure pursuant to section 19a of consent in general. In this context, the Ombudsman referred to the question of whether or not consent pursuant to the treatment provisions of Chapter 5 of the Health Act was also valid in case of measures which were not of a treatment-related nature.

- Did a measure with consent fall quite outside the Psychiatry Act and did this mean that neither substantive nor procedural rules need be observed when there was consent?

- The more explicit scope of the comments to the draft bill in which the definition of force in section 1 (2) of the Psychiatry Act was changed (Folketingstidende (official report of parliamentary proceedings) 2005-06, Schedule A, p. 4238). It appears from the explanatory notes to section 1 (2) that the material criteria for the use of the individual coercive measures were not consequently changed.

- The legal effect of consent being given to an otherwise coercive measure in relation to the Act on Coercive Measures.

- The legal position of minors according to the Act on Coercive Measures in Psychiatry. To which measures could the minor or the custodial parent, re-

spectively, give consent with the result that there was no coercion and that the measure was consequently not covered by the Act on Coercive Measures?

At the same time the Ombudsman concluded the case with respect to the Ministry of Justice.

The meeting between the Ministry of Health and the Ombudsman was held on 17 June 2013. Further to the meeting, the Ministry informed the Ombudsman that according to the Government's legislative programme a bill would be introduced in Parliament in February 2014 with an amendment of the Psychiatry Act, and that the Ministry of Health expected the bill to contain proposals that the legal position of minors in connection with coercive measures appears explicitly in the Psychiatry Act, including channels of complaint, etc.

At the time of submission of this annual report, the Ombudsman was still awaiting a written reply to those questions regarding consent which the Ombudsman mentioned in his letter of 19 December 2012 to the Ministry, and whether there were in the Ministry's assessment a need for initiatives until the time when a possible amendment of the Psychiatry Act could come into force.

4.2. Measures towards juveniles at accommodation facilities

Through monitoring visits to socioeducational accommodation facilities the Ombudsman learned that certain facilities used various measures in the form of for example demands that the juveniles submit urine samples and in the form of limiting the juveniles' use of and access to, among other things, mobile phones, computers and/or the internet in certain cases.

In a letter of 24 August 2012 the Ombudsman invited the (now) Ministry of Social Affairs, Children and Integration to a meeting in order to discuss some fundamental issues connected with the use of these measures. The fundamental issues related to, among other things, the legal authority to use the various measures. At the meeting the Ombudsman would also like to discuss the relationship between section 123a of the Social Services Act and section 72 of the Danish Constitution (whereby house search and seizure requires a judicial order unless otherwise warranted by statute), and between section 123a of the Social Services Act and the Coercive Measures Act. The meeting was held on 23 October 2012.

Following the Ombudsman's inquiry, the Ministry of Children, Gender Equality, Integration and Social Affairs set up a committee on the use of coercion at facilities for

children and juveniles. Part of the committee's tasks was to describe the ethical, legal and practical challenges involved in the use of coercion towards children and juveniles at residential institutions, other places of care, and in foster families. In addition, the committee was charged with making proposals for new rules, if relevant. Jens Møller, General Director at the Ombudsman office, was appointed Chairman of the committee.

The Ombudsman took into account that the issues which he had raised with the Ministry in his letter of 24 August 2012 were being considered by the committee on the use of coercion. Consequently, he decided that on the present basis he would take no further action regarding these issues. At the same time the Ombudsman asked the Ministry of Children, Gender Equality, Integration and Social Affairs to inform him whether the Ministry deemed any measures within this field necessary during the period until the committee submitted its report and any new provisions would come into force, and if yes, which measures the Ministry would implement. The Ombudsman also asked the Ministry to notify him of the committee's report when it had been submitted.

Subsequently, the Ministry of Social Affairs, Children and Integration informed the Ombudsman that the Ministry did find that with regard to the use of coercion towards children and juveniles there was a need for three adjustments which could not await the committee's report and any new provisions following thereof. The Ministry therefore expected to be proposing three amendments (amendment of section 123 (1) of the Social Services Act, amendment of section 123a of the Social Services Act, and authority to use force towards juveniles over 18 placed at a residential institution or accommodation facility according to a criminal decision made as a ruling or passed as a sentence). The Ministry expected the bill with the three amendments to be proposed in Parliament in February 2014 as part of a larger bill with anticipated coming-into-force on 1 July 2014. In addition, the Ministry would notify the Ombudsman of the committee's report when it was available at the end of 2014.

The Ombudsman made a note of the Ministry's information and took no further action in the case, except to await the committee's report.

4.3. Solitary confinement

On 29 February 2012 the Ministry of Justice notified the Ombudsman of the Public Prosecutor's report on the use of remand in solitary confinement in 2010, and of the Ministry's letter to the Legal Affairs Committee of the Folketing regarding said account.

The Public Prosecutor's report states among other things that there were a total of 117 solitary confinements in 2010. The number of solitary confinements had thus decreased by about 40 % compared to the 210 solitary confinements in 2009. It also appears from the report that the average duration of the solitary confinements increased slightly from 22 to 24 days compared to 2009.

There was one solitary confinement with a duration of more than 8 weeks. This solitary confinement lasted a total of 93 days, and the person in question was charged with a criminal offence, namely using the explosive TATP to produce a bomb with the intention of setting it off which, however, he failed to do, as the bomb exploded at the hotel where he was staying. The Copenhagen City Court sentenced the man to 12 years imprisonment.

In 2010, in a homicide case, one young person under the age of 18 was placed in solitary confinement which lasted 17 days.

The Ombudsman acknowledged receipt of the report and did not on the existing basis take any further action in the matter. The Ombudsman asked the Ministry to keep him informed in future of the Public Prosecutor's report to the Ministry of Justice regarding the use of solitary confinement.

4.4. Other investigations

The Ombudsman learned from the website of Hjørring Municipality that the Municipality had started an investigation of several matters concerning the institution Fonden Alternativet with a view to assessing whether the approval of the institution could be maintained. The Municipality had approved the institution as a private accommodation facility for adults pursuant to section 107 of the Social Services Act. On 1 December 2011 the Ombudsman asked the Hjørring Municipality for notification of the result of the Municipality's investigation.

The Municipality informed the Ombudsman that the Municipality had at the end of 2011 started an investigation of the conditions at the institution Fonden Alternativet, and that – since the institution's board had not wished to contribute sufficiently to the investigation of the allegations that had been put forward – the Municipality had on 24 January 2012 revoked the approval of the accommodation facility. The Ombudsman decided not to take any further action in the matter on the present basis.

On 15 November 2010 the UN Committee Against Torture made a decision in the case of a named person vs. Denmark. According to the decision Denmark would be in

violation of Article 3 of the Convention against Torture if the person in question was deported to Iran. On the basis of the decision by the Committee Against Torture, the Danish Refugee Board granted the person a residence permit on 15 December 2010, pursuant to section 7 (2) of the Danish Aliens Act.

On 15 February 2011 the Ombudsman asked the Refugee Board for information on the Board's actions in other cases in the light of the Committee's decision. The Ombudsman aimed specifically at the possibility of resuming cases that had already been concluded. The Refugee Board subsequently made a statement to the Ombudsman, and, on the basis of his review of the case, the Ombudsman did not find sufficient grounds for taking any further action in the case on his own initiative.

On 30 June 2011 the Ministry of Social Affairs asked Fredericia Municipality for a report on the institution Fonden Det Socialpædagogiske Opholdssted Herkules. On the basis of the Municipality's report, which the Ombudsman also received, the Ombudsman asked the Ministry on 21 September 2011 to inform him of what action the case and the Municipality's report had caused the Ministry to take. The Ombudsman also asked the Southeast Jutland police to apprise him of what action DIGNITY's report to the police of, respectively, the Herkules institution and Fredericia Municipality had caused the police to take.

The Ministry of Social Affairs informed the Ombudsman that the Municipality's report did not give the Ministry occasion for taking any further action in the case. At the same time the Ministry informed the Ombudsman that the National Social Appeals Board was investigating the Municipality's supervision of facilities and children and young people placed in care. Subsequently, the Southeast Jutland Police informed the Ombudsman that the investigation had stopped because there was no reasonable presumption that any criminal offence had been committed. The Ombudsman then closed the case.

On 7 March 2011 the Ombudsman asked the Copenhagen Police for an account of the course of events in the clearing by the police of the condemned Scala building. The request was based on the information which had appeared in the daily press concerning the clearing, including in particular that a number of persons had allegedly been sitting on a cold floor for hours without being allowed to go to a lavatory. The Copenhagen Police sent the Ombudsman an account of the course of events, and the Legal Aid organisation Rusk sent a letter to the Ombudsman with criticism of the police's handling of the situation. The Ombudsman did not find grounds for criticising the

behaviour by the police during the clearing of the building, and he consequently closed the case.

5. Deaths, including suicide, and suicide attempts in Prison and Probation Service institutions

5.1. In general

In accordance with an agreement with the Department of Prisons 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.

Departmental notice No. 84 of 23 November 2012 on the institutions' processing and reporting of incidents involving deaths, suicides, attempted suicides and other suicidal or self-harming behaviour among inmates in the care of the Prison and Probation Service came into force on 1 January 2013 and includes incidents after this date. At the same time department notice No. 145 of 14 December 2006 was rescinded.

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 will then make a decision in the case. The Department sends its decision and the case documents to the Ombudsman who reviews the case.

5.2. The cases

In 2012 the Ombudsman opened 42 cases on deaths, including suicides, and attempted suicides in the institutions of the Prison and Probation Service. In 2012 the Ombudsman concluded 25 cases on incidents in 2010, 2011 and 2012.

The majority of the cases were concluded on the basis of the Ombudsman's review of the decisions and case documents from the Department of Prison and Probation Service. The Ombudsman concluded the cases without criticism or recommendations.

In his concluding letter regarding one case involving a death, the Ombudsman informed the Department of Prison and Probation Service that at the next meeting with the Department on cases involving suicide, etc., he would raise the question of the authorities' follow-up on information concerning the substance abuse of specific inmates in the Service's institutions and the institutions' supervision of affected inmates.

In a case involving a suicide attempt, the Ombudsman informed the Department that at a coming meeting with the Department on suicide cases, etc. he would raise the question of the relationship between the basic data's security box and the security record (a question of the way in which the Prison and Probation Service registers suicide attempts).

The Department and the Ombudsman held a meeting on 4 April 2013 at which these issues were discussed, among other things.

In a case concerning a death the Ombudsman asked the Department to state whether there had been any thoughts – and if so, which – of placing the inmate somewhere else, cf. section 78 of the Corrections Act.

On the basis of a review of the documents in the case and the authorities' statements, the Ombudsman decided to take no further action in the case. The Ombudsman emphasised among other things that the institution had specifically considered placing the inmate somewhere else but that particular circumstances meant that the institution had not found this course to be necessary, and that the inmate was not dissatisfied with staying in the institution in relation to the health problems in question.

In a case involving a death, the Ombudsman asked the authorities for a statement regarding the passing on of information on (possible) substance abuse in the institution, and any actions the authorities had taken in consequence of the information which may or may not have been passed on.

Following a review of the case documents and the authorities' statements, the Ombudsman decided to conclude his investigation of the case. The Ombudsman emphasised in particular the information *that* the health care personnel had continuously passed on the necessary information to the staff needing the information, *that* the institution was aware of the inmate's substance abuse, and *that* the institution initiated various treatment measures for the inmate. In this context the Ombudsman stressed his focus on preventive efforts when reviewing cases involving deaths, including suicide, and attempted suicide.

The Department of Prison and Probation Service sent the Ombudsman its memorandum on reportable suicides, deaths, attempted suicides, etc. among the inmates of the Prison and Probation Service institutions in 2011 and the Department's letter of 22 January 2013 to State Prison governors, local prison governors and half-way house

principals on the subject. The Ombudsman acknowledged receipt of the material and informed the Department that he would send the material on to DIGNITY and DIHR, and that the material would be included in the activities of OPCAT in particular.

6. Proposals and observations concerning existing or draft legislation

Article 19 (c) of the OPCAT protocol says that the national preventive mechanism shall have the power to submit proposals and observations concerning existing and draft legislation.

Section 12 of the Danish Ombudsman Act says that if any deficiencies in existing law or administrative regulations come to the attention of the Ombudsman, he shall notify Parliament and the responsible Minister thereof. With regard to deficiencies in local authority bylaws, the Ombudsman shall notify the local authority or regional council thereof.

Pursuant to section 12 (2) of the Ombudsman Act, the Ombudsman shall in connection with his activities monitor that existing laws and administrative regulations are compatible with, in particular, Denmark's international obligations to ensure the rights of children, including the UN Convention on the Rights of the Child. If the Ombudsman becomes aware of any deficiencies, he shall notify Parliament and the responsible Minister thereof. With regard to deficiencies in municipal or regional regulations, the Ombudsman shall notify the local authority or regional council in question. Section 12 (2) was inserted into the Ombudsman Act by Act No. 568 of 18 June 2012 on the amendment of the Ombudsman Act. The provision came into force on 1 November 2012.

Occasionally, the Ministries will contact the Ombudsman regarding up-coming draft legislation in order to have an informal discussion with him regarding the draft. This happens especially in cases in which the Ombudsman has raised general issues with the Ministries on the legal status in particular fields. Cases investigated by the Ombudsman may thus result in a change in the existing legislation (see for example paragraph 4.1 on a search of a psychiatric facility and the legal position of children and juveniles in connection with coercion in psychiatry, and paragraph 4.2. on measures towards juveniles at accommodation facilities).

Together with DIGNITY, Danish Institute for Human Rights (DIHR) is the Ombudsman cooperating partner with regard to the OPCAT field and DIHR reviews draft proposals for new legislation and comments on those proposals. If DIHR considers a legislative

proposal to be particularly relevant to the OPCAT cooperation, DIHR will contact the Ombudsman regarding the proposal and make arrangements for the next stage.

7. Guests and international activities

The Ombudsman and his staff regularly give presentations and lectures for various, both Danish and international, guests on the Ombudsman's activities, including the Ombudsman's function as national preventive mechanism. The guests often come from very different backgrounds but in general they all want to learn more about the Ombudsman institution and its role in a democratic society. The Ombudsman and his staff will therefore always give a general briefing on the institution and its history with a view to a subsequent exchange of experiences and thoughts.

An Ombudsman staff member participated in the 8th Thematic Workshop for European National Preventive Mechanisms on 20-21 March 2012 in Geneva. The workshop theme was "The immigration removal process and preventive monitoring".

The Serbian ombudsman delegation concerning the OPCAT regime visited the Danish Ombudsman on 31 October 2012.

In addition, an Ombudsman staff member participated in a meeting in Copenhagen with the Swedish OPCAT delegation on 19 September 2012, and gave a presentation on the Danish national preventive mechanism in Oslo on 27 November 2012.

8. Monitoring visits pursuant to section 18 of the Danish Ombudsman Act

Monitoring visits according to section 18 of the Ombudsman Act were carried out in 11 institutions in 2012. Deprivation of liberty had occurred in eight of the institutions. The monitoring teams did not during the visits observe any conditions covered by the concept of "torture and other cruel, inhuman or degrading treatment or punishment".

9. Monitoring visits by the Ombudsman's Children's Division

The Ombudsman's Children's Division, which commenced operating on 1 November 2012, carried out a monitoring visit to Behandlingshjemmet Donekrogen, a residential institution for children and juveniles who were or could be deprived of liberty. The Children's Division did not during the visit observe any conditions covered by the concept of "torture and other cruel, inhuman or degrading treatment or punishment".

10. 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 liberty.

This purpose entails that the Ombudsman, DIGNITY and DIHR shall in connection with the visits be for example especially focused on 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 resident's injuries, and the use of 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 OPCAT regime.

As national preventive mechanism the Ombudsman has chosen, together with DIGNITY and DIHR, to concentrate on a number of areas which are considered especially relevant to the conduct of the particular monitoring task. The choice of focus areas for the visits is, among other things, based on the contents of the reports on Denmark from the European Committee for the Prevention of Torture, etc., and from the UN Committee Against Torture, and on the knowledge which the Ombudsman, DIGNITY and DIHR already possess regarding conditions for persons in Denmark who are deprived of their liberty.

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

10.1. Relationship between staff and persons deprived of liberty

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

10.2. Health issues

Whether or not persons deprived of liberty and other institutionalised persons are treated with dignity, humanely and without torture is an assessment which is dependent on, among other things, the institution offering healthy living conditions and good access to medical care and other health care services. Basically, persons deprived of 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 liberty are often already ill or otherwise vulnerable, and a continued and comprehensive treatment of them is essential. Finally, it is of course particularly important to keep an eye on persons deprived of 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 topics:

- Health care services in the institution
- Health and illness among the persons deprived of liberty
- Conditions which may influence health and cause illness among persons deprived of 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 example 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 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 institutions the access to consultations in or outside the institution, for example with own general practitioner, is important.

Correspondingly, the *quality of the health service* is an important factor. Here, the focus is on, among other things, the staffing of doctors, nurses, etc. with regards to hours in relation to number of users, and whether the health staff has the qualifications expected in the general healthcare system. Which forms of treatment are available in the institution and which treatments require a referral to the general health care system outside the institution is of great importance. This is of special significance be-

cause for example 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 daytime opening 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 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 example solitary confinement, the 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 example the institutions of the Prison and Probation Service where the inmates of local and State Prisons normally have to use the prison's doctor. In these instances, the incarcerated person is to a higher degree dependent on being able to establish a good rapport with the prison doctor. If for various reasons a fundamental disagreement between the patients and the doctor should occur, it is important to look into the possibility – as outside the prison – of consulting another doctor (getting a second opinion).

Health and illness among persons deprived of liberty

An obvious prerequisite 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 later on. It is therefore crucial that the procedures used by the health care service on arrival of the user ensure that important health conditions requiring treatment are identified and that on-going treatment already in place is reported so that this treatment will continue.

Likewise, when the user leaves the institution (is for example 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 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. Mentally ill persons, for example, do not normally belong in a prison, but in a psychiatric facility.

In prisons and other institutions for incarcerated persons there is an increased risk of contagious diseases, such as for example 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 a higher risk of infection than in society at large in institutions where many people live under the same roof. Consequently, the state of illness and health in the institution should be monitored, for example through an illness and health information system capable of indicating 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 for example the institution's psychological environment which is dependent on safety, incidence of violence, threats, use of solitary confinement, 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 as an anxiety disorder may be at 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 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 institutions 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 that are not being covered. The visiting team *inspects* the available facilities (for example treatment facilities, record storage, drugs storage, solitary confinement rooms and mechanical restraints) and interviews those users who asks for or consents to interviews. These interviews may focus on the users' experience of the institution's 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.

The specific conditions of relevance to the individual visit depend on the type of institution being visited. Obviously, health service conditions involved in the visit must be different in a prison from those in a psychiatric facility.

10.3. 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.

Consequently, the use of solitary confinement has been selected as a focus of interest. During the monitoring 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.

10.4. 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 insti-

tutions 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 monitoring visits.

11. Work method

Visits to places where person are or may be deprived of liberty are the central instrument in the work pursuant to the OPCAT regime. Accordingly, the Ombudsman's activities are based on such visits.

According to the OPCAT regime, 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 medical doctor from DIGNITY. Representatives from DIHR will also participate to a relevant extent.

The Ombudsman decides, together with DIGNITY and DIHR, which institutions to visit.

In 2012, as in previous years, the Ombudsman decided together with DIGNITY and DIHR that the majority of the visits would go to specific types of institutions. As mentioned in paragraph 2.1., the visits in 2012 went to 3 State Prisons, 2 psychiatric facilities, 6 socioeducational accommodation facilities (of which 3 were also temporary accommodation facilities for adults), 2 temporary accommodation facilities for adults, 6 nursing homes, 3 asylum centres, one Prison and Probation Service half-way house, one local prison, one residential institution and one secure residential institution. In total, the Ombudsman visited 47 branches in 26 institutions.

When the visiting teams see several institutions of the same type, they gain a good insight into the individual institution type. The visiting teams may also directly combine knowledge, experience and observations between institutions of the same type. The visiting teams may for example share this information with the institutions and include it in the discussions with the institutions during the visits. Through this process, the teams 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 important 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 example combine information about staff's approach to the use of force in social institutions compared to psychiatric centers.

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 prior to the visit, and that the relevant persons are actually present at the institution on the day of the visit. In 2012 advance notice was given for all but 4 visits to institutions.

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 is informed about the institution's practices, such as for example the institution's use of force. This enables the visiting team to have a better focus on those conditions which are particularly relevant to the institution in question.

Besides asking the institutions visited by the Ombudsman in 2012 for information of a factual nature, the Ombudsman also asked the institutions for a brief account (max 2 pages in total) of, for example, the following:

- What preventive measures the institution has in place to ensure that users do not end up in inhuman or degrading situations
- What major problematic incidents the institution has experienced within the last 12 months
- Which professional (not economic) main challenges the institution has faced in 2012
- How the users' access to medical treatment is organised
- The use of temporary staff replacements

There were several reasons why the Ombudsman asked the institutions for such an account. First and foremost, the account will help the visiting team to target its questions more precisely during the visit, as the team will, prior to the visit, have been apprised of, among other things, significant problematic incidents and will therefore be in a position to ask more detailed questions about such incidents. In addition, the account could save time during the actual visit in those instances where the account gives satisfactory answers to matters about which the team would normally ask questions. The institution's account is part of the Ombudsman's standard practice in the preparation of monitoring visits.

During a visiting year, the Ombudsman will basically ask for the same information from similar types of 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 types of institution.

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

Dialogue plays a large part in the visits.

Consequently, a visit usually starts off with a meeting with the institution's management. The discussion at the meeting is typically based on the focus areas and the material which the team has received prior to the visit. The use of force, for example, is usually discussed. Specific incidents at the institution may also be discussed.

During the visit the team will usually not only have meetings with the management but also with the staff and the users, and often also with health care personnel, representatives for the users and relatives of the users.

The visiting team will also walk round parts of the institution which will provide the team with an impression of the atmosphere and the daily routine in the institution. During this tour of the premises, the team will often ask additional questions and will also frequently talk with for example members of staff and the institution's users whom the team encounters during the tour.

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

First and foremost, the visiting team will convey relevant information to the institution's management at the concluding meeting. This may be for example 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, such as for example municipalities, the police and mental health services.

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

Most comments will be given verbally at the concluding meeting, and the visiting team may also then just mention matters which have come to the team's attention during the visit, for example the way in which the institution registers violence and threats.

If the monitoring visit does not give grounds for representations, criticism, recommendations or other written comments, the Ombudsman will close the visit with a case note on the visit's key points, and a short, concluding letter to the institution which will contain a description of the visit and the Ombudsman's assessment of the conditions at the institution. The institution is asked to make the contents of the letter known to the users. Recommendations and comments which have been given verbally at the concluding meeting, and which the responsible authorities agree with and will follow, will not usually be mentioned in the concluding letter regarding the monitoring visit, but only in the case note thereon.

In some instances a problem will not find a solution during the visit. In these cases the Ombudsman will sometimes find it expedient to telephone the institution after the visit and ask what action the institution has taken – or will take – to solve the problem. If the problem is solved through such contact over the telephone, the Ombudsman will not normally have grounds for making any written comments to the responsible authorities. However, in many cases the Ombudsman will mention the solution found to the problem in his concluding letter to the institution.

Dating from 1 January 2013, it will be registered in the Ombudsman's statistics system if he makes various verbal recommendations, suggestions, etc. during monitoring visits, including OPCAT visits, (or perhaps on the telephone following the visit) which are not reflected in the subsequent written conclusion to the case in the form of actual criticism or recommendation.

If a monitoring visit gives grounds for considering suggestions, criticism, recommendations or other written comments, the Ombudsman will ask the authorities for a written statement before deciding whether those grounds are still valid. Once the Ombudsman has the authorities' reply, a report or a letter to the authorities will be prepared. The institution will be asked to make the content of the letter to the institution known to its users. Recommendations and criticism will be registered in the Ombudsman's statistics system as usual.

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

Apart from visits, other methods are also being used in order to investigate and prevent torture, etc. The Ombudsman may for example investigate cases on his own initiative and ask for information, statements and case documents. This power may be combined with visits. Information which the Ombudsman receives in the course of the visits may for example prompt him to raise a case on his own initiative or to have meeting with the relevant authority. The Ombudsman may also choose to raise a case on his own initiative based on media reports of specific matters.

12. Legal basis for and organisation of OPCAT visits

On 19 May 2004 the Danish parliament, Folketinget, adopted the ratification of the optional protocol to the UN Convention against Torture and Other Cruel, Inhuman or 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 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 detail in Article 19 of the protocol. The main task is to carry out regular visits to places where persons are deprived of 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 recommendation to the relevant authorities with a view to improving the treatment of and conditions for persons deprived of liberty. Finally, the national preventive mechanism shall make suggestions and comment 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 with a bearing on whether or not there is a possible future risk of torture or other degrading and inhuman treatment.

In Article 4.1., OPCAT states that the visits shall be focused on the treatment of persons in places where they are or may be deprived of liberty. 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 ensure among other things that the Parliamentary Ombudsman has the necessary legal base to carry out visits to private institutions in accordance with the OPCAT mandate, 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 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 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 just over 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 2012 for participating in the visits, while DIGNITY could receive up to 400,000 DKK for making their medical expertise available for the task. DIGNITY’s funds are allocated from the budget of the Ministry of Foreign Affairs.

As previously stated, it is the 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 orga-

nisations carry a decisive weight, and that he will let any divergent views be reflected in the case reports, if the organisations should so wish.

The executive of the three organisations meet at least once a year to discuss and plan the general guidelines for the work. This part of the cooperation is called *the council*.

Each of the three organisations has appointed specific staff officers who participate in the running process of carrying out visits, preparing visit reports, etc. Staff at the Parliamentary Ombudsman office acts as secretariat and has the overall responsibility of organising the activities. This part of the cooperation is called *the working group*.

13. Assessment basis

13.1. In general

The rules governing the basis for the Ombudsman's assessment appears from the Ombudsman Act. The actual authority granted to the Ombudsman to carry out inspections is found in Section 18 of the Ombudsman Act according to which the Ombudsman "may inspect any institution or firm or place of employment which fall within the jurisdiction of the Ombudsman". By Act No. 502 of 12 June 2009 the Ombudsman Act was amended with a view to, among other things, establishing the legal basis for the Ombudsman to carry out the task as national preventive mechanism pursuant to the OPCAT regime.

OPCAT visits focus on places where person are or may be deprived of liberty. The purpose of the visits is to prevent violations of the UN Convention against Torture, Article 3 of the European Convention on Human Rights (ECHR), and other international regulations based on those two protocols. Apart from Article 3 of the ECHR, the specific rules governing the individual institutions will also be included in the basis for the Ombudsman's assessment of its conditions, for example the Sentence Enforcement Act and the Psychiatry Act. In addition, the UN Convention against Torture, the Optional Protocol to the Convention against Torture (OPCAT), particularly Article 19, and reports and recommendations from the UN Subcommittee on Prevention of Torture and the European Committee for the Prevention of Torture, etc. are included, together with case law.

13.2. International assessment 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 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).

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.

13.2. 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 proto-

col 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.

13.3. 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.

13.4. Cruel, inhuman and degrading treatment

OPCAT 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 a 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 specific 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, special 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.

13.5. 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 these 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, 23 December 2013