THE DANISH
PARLIAMENTARY
OMBUDSMAN

Monitoring Activities 2016

Extracts from the Annual Report of the Danish Parliamentary Ombudsman

PREFACE

This publication contains an extract of the pages from the 2016 Annual Report of the Danish Parliamentary Ombudsman which relate specifically to the Ombudsman's monitoring activities.

The extracted material on pages 70-112 is unchanged from the Annual Report, and the original pagination has been maintained.

The summaries of selected statements and the news on the last pages also relate specifically to the Ombudsman's monitoring activities.

The 2016 Annual Report of the Danish Parliamentary Ombudsman can be read in full on www.ombudsmanden.dk or obtained in book form from the Ombudsman's office.

MORE OPENNESS IN THE OMBUDSMAN'S MONITORING ACTIVITIES

Over the years, the Ombudsman's monitoring activities have increased to 50-60 annual monitoring visits to prisons, psychiatric wards and other institutions. In future, the outcome of the visits will be made public on a continuing basis, and a more methodical contact with civil society will be introduced. This is the result of a comprehensive in-house evaluation of the Ombudsman's monitoring concept.

Jonas Bering Liisberg
Director General

Since 1955, the Ombudsman has visited public institutions in order to experience with his own eyes and ears how the authorities are treating citizens. The focus of these inspections, as they were originally called, is institutions where persons are deprived of their liberty or have to stay due to difficult circumstances in their lives.

Over the years, the scale of the visiting activity has gone up quite a lot. This is not least due to the Ombudsman's responsibility for preventing violation of the UN Convention against Torture in Denmark, a task with which he was entrusted in 2009. The task as 'national preventive mechanism' (NPM) was given to the Ombudsman in continuation of Denmark's ratification of the Optional Protocol to the UN Convention against Torture, abbreviated as OPCAT. The establishment of a special Children's Division in 2012 meant an expansion of the monitoring activity. Today, the Ombudsman carries out a total of 50-60 annual monitoring visits in close collaboration with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights.

Thus, the monitoring activities constitute a considerable part of the Ombudsman's overall activities. But this kind of activity has been less publicly exposed than our other activities. This is probably first and foremost due to the fact that to a great extent the aim is preventive and based on informal recommendations and dialogue with the individual institutions during the visits rather than formal recommendations and criticism after thorough, written investigations. A quiet diplomacy, you could say.

Also in future, we shall emphasise the quiet and efficient diplomacy but at the same time create as much transparency as possible. Therefore, since the turn of the year we have published the outcome of the individual monitoring visits on www.ombudsmanden.dk on a continuing basis.

Increased openness and knowledge sharing are a connecting thread in the few but important changes in the Ombudsman's monitoring concept which are the result of an in-house evaluation implemented by the Ombudsman in 2016 together with his collaborators within this field, DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights.

NEWS STORIES ARE CONSIDERED AFTER EACH MONITORING VISIT

Sometimes, we publish news stories about specific visits. One of the reasons for doing so may be that during a visit we have become aware of particular, serious matters in an institution, or that the general public has great focus on a specific institution or issue.

In 2016, we have published a number of these kinds of news stories on www.ombudsmanden.dk and submitted the news to the approx. 3,200 subscribers – for example when, at the beginning of the year, we visited a girl who was held in solitary confinement and later on in connection with a monitoring visit to Vridsløselille, where detained asylum seekers are placed (The Ombudsman's Case No. 2016-56).

As an institution, we have previously been very cautious about posting news stories concerning the individual visits. Instead, we have focused our attention on communicating the outcome of the visits in a broader perspective, especially in connection with annual thematic reports. It has now been decided that it must always be taken into consideration when we conclude a monitoring case whether a news story should be published.

It is probable that also in the future relatively few monitoring cases will have the potential to become news stories. But there are ways of opening up, sharing

NEWS STORY PUBLISHED 4 FEBRUARY 2016 ON WWW.OMBUDSMANDEN.DK

Staff of Ombudsman's Children's Division visit 15-year-old girl held in solitary confinement

Staff of the Ombudsman's Children's Division have, together with representatives of the Institute for Human Rights and DIGNITY – Danish Institute Against Torture, visited a 15-year-old girl who has been in solitary confinement since 14 January 2016. It is extremely rare for minors to be held in solitary confinement.

The purpose of the monitoring visit was to check that the girl was treated in a dignified and considerate manner and in accordance with her rights. During the visit, the visiting team focused on aspects such as the girl's health situation and her access to activities, including leisure activities, and education.

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knowledge and engaging in dialogue with the surrounding world which can contribute towards the primarily preventive aim of the monitoring activities.

2012 MONITORING CONCEPT CONFIRMED

The evaluation has largely confirmed the existing monitoring concept, which was introduced in 2012 and fundamentally changed our approach to the task at the time.

The changes in 2012 were aimed at concentrating our efforts on significant and serious matters and focus our attention on general problems, for example health services in all prisons in the country rather than matters quite specific to the individual institution, such as the physical layout of a prison.

In 2012, a number of focus areas were defined – among others forcible measures and other restrictions, interpersonal relations and health issues – which constitute the backbone of a standard monitoring visit. In addition to this, it was decided that every year one or more themes will be selected across institution types. In past years, we have published reports on, for instance, the prevention of violence and threats among users (theme in 2013) and placements in security cells (theme in 2015).

The changes effected in 2012 also meant that we now use fewer resources on long written procedures; instead we are able to visit more places in the course of a year and conclude the individual cases faster, primarily on the basis of verbal dialogue.

The conclusion of the 2016 evaluation is that the concept from 2012 basically works as intended and ensures an efficient utilisation of our resources for the task.

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NEWS STORY PUBLISHED 20 SEPTEMBER 2016 ON WWW.OMBUDSMANDEN.DK

Greatly improved conditions for foreign nationals detained at Vridsløselille

Following the Ombudsman's two monitoring visits and his dialogue with the responsible authorities, the conditions for the foreign nationals who are detained at Vridsløselille have been greatly improved.

They are no longer locked up in prison cells almost around the clock but are now able to move around communal areas and spend time with each other there. In addition, a number of leisure and work activities are now available.

'These people were detained under unnecessarily hard conditions which could have harmful effects on some of them. So I am pleased that the authorities have responded quickly and at least improved conditions in a number of important respects', says the Parliamentary Ombudsman, Jørgen Steen Sørensen. (...)

MONITORING VISITS GIVE RISE TO IMPORTANT INVESTIGATIONS

It happens that during visits we become aware of issues which cannot be dealt with on the spot but require further investigations and follow-up. Eventually, these issues may end up as separate Ombudsman cases. Thus, the monitoring visits are an important source of investigations opened on the Ombudsman's own initiative.

In 2016, we have published news stories about several investigations which originate in monitoring visits, for example investigations within the children's social care sector concerning, respectively, the lack of action plans for children placed in care (the Ombudsman's Case No. 2016-44) and insufficient teaching of children placed in care (news stories on 14 January and 23 December 2016).

Today, monitoring visits are normally concluded with a relatively short letter from the Ombudsman. If the visiting team has given verbal recommendations, these will be summarised in the letter. If the visit has resulted in separate investigations, this will usually also appear from the letter. These are the letters which, as a new thing this year, we will post on www.ombudsmanden.dk on a continuing basis.

In this way, those interested can stay updated on which institutions the Ombudsman has visited and the outcome of the visits. Publication of the letters will hopefully also contribute to boost the effect of recommendations because the media, civil society and – last but not least – inmates and users are given the possibility of 'assisting' with the implementation of the recommendations.

MEETINGS WITH CIVIL ORGANISATIONS

Another initiative towards more openness and knowledge sharing for which the evaluation prepares the ground is the preparation of a 'live' catalogue of standard informal recommendations. The catalogue is to function partly as a source of inspiration, partly as a general guideline for institutions and authorities.

In addition, in his efforts to increase openness about the monitoring activities, the Ombudsman will in future to a larger extent involve organisations from civil society; both actual user organisations and organisations working with civil rights and human rights on a broader scale. Typically, this will happen at annual meetings where inspiration for the monitoring work can be found and knowledge shared about the Ombudsman's activities. The first meeting of this kind was held in May 2016 with participation of representatives from approx. 20 organisations.

MONITORING TEAMS WILL PAY VISITS TO USERS TO A LARGER EXTENT

As far as preparation and execution of the visits are concerned, our colleagues in the other Nordic countries have inspired us to make an important change: In future, the visiting teams will to a larger extent select the inmates and residents they wish to talk to. This will ensure that the visiting teams obtain as true and fair a view as possible. There may, for example, be prison inmates who do not actively seek an interview but nevertheless have important information to share with the visiting team. These could be foreigners who do not speak Danish, persons with a disability, or inmates in a punitive cell.

So far, we have primarily received input from users who have requested an interview with the Ombudsman, if the visit was announced beforehand. However, notices will still be posted prior to the visit in which users are told about the possibility of an interview. As a main rule, a wish for an interview will be met.

The new practice with proactive talks with inmates and users will require more time. We shall therefore in future undertake visits of varying extent and intensity, including shorter but more focused visits, so that we can reach the same number of visits as before.

The Ombudsman has published the new general manual for monitoring activities on www.ombudsmanden.dk. Here you can read in detail how the visits are planned and carried out.

MONITORING ACTIVITIES

- Adults
- Children

THE OMBUDSMAN'S MONITORING VISITS

Where

The Ombudsman carries out monitoring visits to public and private institutions, especially institutions where persons are or may be deprived of their liberty, such as, for example, prisons, social care institutions and psychiatric wards.

Why

The purpose of the Ombudsman's monitoring visits is to help ensure that daytime-users of and residents at institutions are treated with dignity and respect and in compliance with their rights.

The monitoring visits are carried out in accordance with the Ombudsman Act as well as the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Pursuant to this Protocol, the Ombudsman has been appointed 'national preventive mechanism'. The task is carried out in collaboration with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights who contribute with medical and human rights expertise.

The Ombudsman has a special responsibility to protect the rights of children in accordance with, among others, the UN Convention on the Rights of the Child.

How

During the monitoring visits, the Ombudsman often makes informal, verbal recommendations to the institutions. The recommendations are typically aimed at improving conditions for users of the institutions, including adjustment of conditions in order to comply with the rules. They can also be aimed at preventing, for example, degrading treatment.

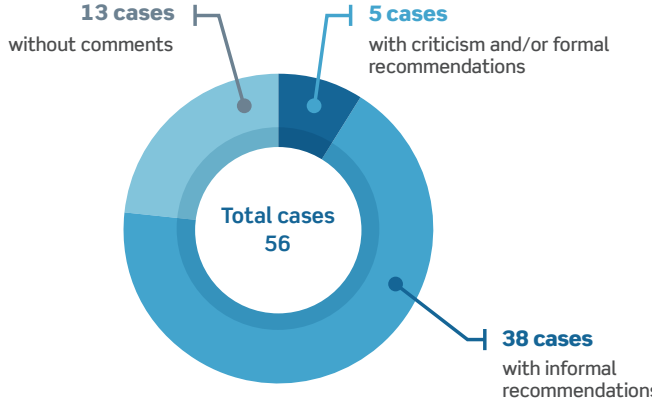
Monitoring visits may also cause the Ombudsman to investigate general problems.

Who

The Monitoring Department carries out monitoring visits to institutions for adults, whereas the Ombudsman's Children's Division carries out monitoring visits to institutions for children. The Ombudsman's special advisor on children's issues participates in monitoring visits to institutions for children and, if deemed relevant, also in monitoring visits to institutions for adults.

Usually, a medical doctor from DIGNITY – Danish Institute Against Torture participates in the visits, and a human rights expert from the Danish Institute for Human Rights will often participate too.

MONITORING CASES CONCLUDED IN 2016



In regard to institutions for adults, the Ombudsman also concluded:

14 monitoring-related cases taken up by the Ombudsman on his own initiative. 7 cases resulted in criticism or formal recommendation.

29 cases about suicide attempts, deaths etc. at Prison and Probation Service institutions or in police custody. Criticism was expressed in 1 case.

In regard to institutions for children, the Ombudsman also concluded:

22 monitoring-related cases taken up by the Ombudsman on his own initiative. Criticism was expressed in 8 cases.

International activities

In 2016, three meetings were held with representatives from the other Nordic ombudsmen, and eight meetings were held with other foreign ombudsmen etc. with discussion and exchange of experiences about the monitoring activities.

In addition, the Ombudsman had a meeting in 2016 with a representative from the United Nations High Commissioner for Refugees (UNHCR) about the Ombudsman institution's monitoring visits.

Other activities

In 2016, the Ombudsman carried out an in-house evaluation of his concept of monitoring visits in collaboration with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights. Please see the Ombudsman's manual for monitoring activities on the website www.ombudsmanden.dk under 'Monitoring visits'. Please also see the article on pages 70-75.

As a new thing in 2016, the Ombudsman invited representatives from civil society to an information meeting about the Ombudsman's monitoring activities.

MONITORING ACTIVITIES – ADULTS

MONITORING VISITS, ADULTS

No.	Date	Name and location of institution	DIGNITY participated	Danish Institute for Human Rights participated (IMR)	
1	13 January	'Københavns Fængsler', Vestre Hospital (follow-up visit)	✓	✓	
2	20 January	'Blegdamsvejens Fængsel', Copenhagen	✓	✓	
3	21-22 January	'Kofoedsminde', Rødby	✓		
4	2 February	'Højsletten', Herlev	✓		
5	3 February	'Psykiatrisk Center Sct. Hans', Roskilde	✓		
6	29 February	'Institution Vridsløse-lille', Albertslund (**unannounced** visit)	✓	✓	
7	9-10 March	'Horserød Fængsel', Elsinore	✓	✓	
8	15 March	'Psykiatrien Syd', Vordingborg	✓		
9	16 March	'Sønderborg Arrest'			
10	17 March	'Aabenraa Arrest'			

1) Number of inmates, residents and patients etc. who had talks with the visiting teams.

2) Number of relatives, guardians, social security guardians and patient advisors who had talks with the visiting teams.

3) The users' level of function made talks impossible.

	Talks with users[1]	Talks with relatives and others[2]	Type of institution and target group
	8	0	Prison section, especially for mentally ill remand prisoners during investigation of their case
	5	0	Prison, especially for remand prisoners during investigation of their case
	16	0	Secure sections in a special institution for persons with mental disabilities who have been sentenced to placement in an institution
	0[3]	4	Municipal accommodation facility for adults with considerably and/or permanently impaired functional capacity
	5	1	Two bed units for general psychiatric patients
	9	0	Closed Prison and Probation Service institution for foreign nationals who are detained under the Aliens Act
	16	0	Open prison for persons serving time, including a closed section
	9	5	Two bed units for general psychiatric patients
	7	0	Prison, especially for remand prisoners during investigation of their case
	5	0	Prison, especially for remand prisoners during investigation of their case

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MONITORING VISITS, ADULTS

No.	Date	Name and location of institution	DIGNITY participated	Danish Institute for Human Rights participated (IMR)	
11	30-31 March	'Jyderup Fængsel'	✓	✓	
12	7 April	'Brønderslev Psykiatriske Sygehus'	✓		
13	19 april	'Hellebo Hus', Holbæk	✓	✓	
14	26 April	'Hedegaard', Skjern			
15	27 April	'Nørholm', Herning			
16	9 May	'Botilbuddet på DNS', Ulfborg	✓		
17	10 May	'Botilbuddet Vestergård", Hornslet	✓		
18	10 May	'Lille Eje', Hornslet	✓		
19	11 May	'Politigårdens Fængsel', Copenhagen (**unannounced** visit)	✓	✓	
20	13 May	'Psykiatrisk Center Nordsjælland', Hillerød	✓	✓	
21	26 May	'Regionspsykiatrien Horsens'			

	Talks with users[1]	Talks with relatives and others[2]	Type of institution and target group
	25	0	Open prison, especially for persons serving time, including a section for young persons and a prison section
	4	3	Two bed units for general psychiatric patients
	2	1	Private accommodation facility for adults with a combination of problems, such as mental disability combined with a psychiatric disorder and/or abuse
	3	0	Private 24-hour institution for mentally disabled young persons and adults who need special support
	6	0	Regional accommodation facility for adults with permanently impaired mental functional capacity
	3	4	Private accommodation facility for adults with impaired physical and/or mental functional capacity
	1	1	Municipal accommodation facility for adults with impaired mental functional capacity
	1	1	Municipal accommodation facility for adults, especially for convicted persons with mental disabilities
	1	0	Special prison unit for, among others, negatively strong inmates. The monitoring visit concerned the conditions for a particular inmate who had been excluded from association for more than 90 days
	4	3	Two bed units for general psychiatric patients
	4	6	Two bed units for general psychiatric patients

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MONITORING VISITS, ADULTS

No.	Date	Name and location of institution	DIGNITY participated	Danish Institute for Human Rights participated (IMR)	
22	3 June	The police detention facility in Odense (**unannounced** visit)	✓		
23	4 June	The custody reception area at police headquarters in Aarhus (**unannounced** visit)	✓		
24	4 June	The police detention facility in Aarhus (**unannounced** visit)	✓		
25	6 June	The police custody reception area at Vagar Airport, the Faroe Islands	✓	✓	
26	7 June	The local prison in Tórshavn, the Faroe Islands	✓	✓	
27	8 June	The police detention facility in Klaksvík, the Faroe Islands	✓	✓	
28	8 June	The police custody reception area in Tórshavn, the Faroe Islands	✓	✓	
29	9 June	The police detention facility at Tvøroyri, the Faroe Islands	✓	✓	
30	22 June	'Vridsløselille Fængsel', Albertslund (follow-up visit)	✓		
31	23 August	'Møgelkær Fængsel', Juelsminde	✓		

	Talks with users[1]	Talks with relatives and others[2]	Type of institution and target group
	0	0	Police detention facility, especially for persons who are unable to care for themselves due to intoxication and who have been encountered by the police in a dangerous situation
	0	0	Police custody reception area, especially used for short detention purposes for persons taken into custody and awaiting further interrogation
	2	0	Police detention facility, especially for persons who are unable to care for themselves due to intoxication and who have been encountered by the police in a dangerous situation
	0	0	Police custody reception area, especially used for short detention purposes for persons taken into custody and awaiting further interrogation
	3	0	Local prison, especially for remand prisoners during investigation of their case but also sections for persons serving time
	0	0	Police detention facility, especially for persons who are unable to care for themselves due to intoxication and who have been encountered by the police in a dangerous situation
	0	0	Police custody reception area, especially used for short detention purposes for persons taken into custody and awaiting further interrogation
	0	0	Police detention facility, especially for persons who are unable to care for themselves due to intoxication and who have been encountered by the police in a dangerous situation
	19	0	Closed Prison and Probation Service institution for foreign nationals who are detained under the Aliens Act
	34	0	Sections in an open prison, including a section for women

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MONITORING VISITS, ADULTS

No.	Date	Name and location of institution	DIGNITY participated	Danish Institute for Human Rights participated (IMR)	
32	24 August	Aarhus University Hospital, Risskov	✓		
33	29 August	'Københavns Fængsler', Vestre Prison	✓	✓	
34	6 September	Asylum Centre Herning	✓	✓	
35	28 September	'Udrejsecenter Sjælsmark', Hørsholm	✓	✓	
36	4 October	'Station Vest A/S', Brovst (**unannounced** visit)	✓	✓	
37	13 October	'Alternativet', Hjørring[4]			
38	26 October	The police detention facility in Albertslund (**unannounced** visit)	✓	✓	
39	26 October	The police detention facility in Næstved (**unannounced** visit)	✓	✓	
40	31 October	'Udrejsecenter Kærshovedgård', Ikast	✓	✓	
Total	**40** visits		DIGNITY participated in **34** visits	IMR participated in **20** visits	

4) The monitoring visit was carried out under the direction of Henrik Bloch Andersen, High Court Judge, as ad hoc Ombudsman, because the Ombudsman declared himself disqualified. The Ombudsman's office provided secretariat assistance.

	Talks with users[1]	Talks with relatives and others[2]	Type of institution and target group
	4	0	Two bed units for general psychiatric patients
	6	0	Prison, especially for remand prisoners who are isolated by order of the courts, with compulsory or voluntary exclusion from association or sentenced to placement in a punitive cell
	5	0	Accommodation facility for asylum seekers who are awaiting processing of their case
	8	0	Departure centre, especially for rejected asylum seekers who must leave the country
	4	0	Accommodation facility for asylum seekers who cannot currently be accommodated in the ordinary asylum system
	3	2	Individual support programmes[5] in private accommodation facilities, especially for adults with considerably impaired mental functional capacity – often combined with other problems
	0	0	Police detention facility, especially for persons who are unable to care for themselves due to intoxication and who have been encountered by the police in a dangerous situation
	0	0	Police detention facility, especially for persons who are unable to care for themselves due to intoxication and who have been encountered by the police in a dangerous situation
	17	0	Departure centre for rejected asylum seekers, among others
	239 talks	**31** talks	

5) The term 'individual support programmes' is used as a general term for special accommodation facilities for citizens with challenges which make it impossible to accommodate them in other specialised facilities – for instance, when they require a staffing level of at least 1:1.

EXAMPLES OF IMPORTANT RESULTS

Themes

Every year, the Ombudsman selects one or more themes for the Monitoring Department's monitoring visits in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

You can learn more about the themes and find the thematic reports at www.ombudsmanden.dk (choose English) under 'Publications'.

THEME IN 2016: BODY SEARCHING AND URINE SAMPLING

The Ombudsman's key conclusions and recommendations

- After monitoring visits to 24 Prison and Probation Service institutions, psychiatric institutions and social services institutions, the Ombudsman concluded that body search and urine sampling were generally undertaken in accordance with the rules and – to the extent possible – carried out in a manner that was dignified and respectful towards the citizens.

- As far as the Prison and Probation Service institutions are concerned, the visits identified a need for further information to the inmates on why and how a body search is undertaken and how urine sampling is carried out together with information about complaint options. The Ombudsman provided one or more recommendations regarding this issue to all the institutions.

Discussions with key authorities

Placement in security cells: Further to the Ombudsman's thematic report of 2015 regarding placement in security cells, the Department of the Prison and Probation

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Service informed the Ombudsman at a meeting that a number of initiatives had been implemented to ensure that rules are observed. The Department had, among other things, written to the regional offices of the Prison and Probation Service requesting an individual plan on this matter. The Department also issued a new guide.

Radicalisation: At his annual meeting with the Department of the Prison and Probation Service, the Ombudsman discussed the procedures for reporting inmates' radicalisation and extremism to the Prison and Probation Service. The Ombudsman pointed out the importance of ensuring the inmates' legal rights in this connection. Subsequently, the Ombudsman opened a case about the issue on his own initiative. The case was still pending at the end of the year

Balance between force and care: The Ombudsman's theme in 2015 about individual support programmes in the social services sector uncovered a number of dilemmas, especially about the balance between force and care. At a meeting, the Ministry for Children and Social Affairs stated that in 2017 the rules on the use of force will undergo a service check – with focus on the balance between force and care, among other things. The Ombudsman also discussed his findings with the Ministry of Health so they could be incorporated into future initiatives concerning health treatment of permanently incapacitated persons.

Asylum centres: After monitoring visits to a number of asylum centres, the Ombudsman discussed various issues which the monitoring visits had raised, among others accommodation conditions at some places and the need for written instructions to the staff about the use of force and the prevention of violence and threats. The Danish Immigration Service took note of the Ombudsman's comments and indicated that they would consider the questions.

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Cases (concluded in 2016) opened after monitoring visits

Use of force in halfway houses of the Prison and Probation Service: During a monitoring visit to one of the Prison and Probation Service's halfway houses, it emerged that force and handcuffs had been used on a resident. The Ombudsman opened a case regarding the legal basis for this procedure. The outcome of the case was that the Department of the Prison and Probation Service changed its administrative regulations. (The Ombudsman's Case No. 2016-18).

Investigation of inmates' complaints about rough treatment: During a monitoring visit to a local prison, a number of inmates said that an inmate had been pushed several times by a prison officer. The Ombudsman opened a case, especially regarding the authorities' investigation of the incident. The case was concluded with criticism. At the same time, the Ombudsman asked the Department of the Prison and Probation Service to consider implementing rules in their protocol on investigation of complaints from inmates about rough treatment – also based on two other cases about the same subject which the Ombudsman concluded in 2016. (The Ombudsman's Case No. 2016-52).

Detained foreign nationals: Two monitoring visits to one of the Prison and Probation Service institutions for foreign nationals who are detained pursuant to the rules of the Aliens Act caused the Ombudsman grave concern. Therefore, the Ombudsman entered into a dialogue with the Department of the Prison and Probation Service. Subsequently, the conditions for the detainees were changed and improved on a number of important points. (The Ombudsman's Case No. 2016-56).

The Prison and Probation Service in Greenland: Further to monitoring visits to four Greenland institutions for convicted persons, the Ombudsman inquired into, among

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other things, the handling of underage persons and women and forcible measures. The case was closed with criticism. The Ombudsman also noted that the Ministry of Justice had stated that in connection with the next amendment of the Greenland Criminal Act, steps would be taken to change the Act's rules on forcible measures.

Placement in police detention facilities: Unannounced monitoring visits to two police detention facilities for intoxicated persons resulted in criticism, among other things because the police reports on detention were in general insufficient. The Ombudsman also noted that the police had initiated a number of measures to ensure that similar inadequacies were avoided in future and that the Danish National Police would follow up on the effect of the measures. (The Ombudsman's Case No. 2016-21).

Use of special harnesses etc.: A monitoring visit to a municipal accommodation facility raised doubts about the facility's authority to use various types of harnesses and other protective measures towards a resident. Therefore, the Ombudsman took up a case against the municipality. When the municipality later stated that it had stopped using the harnesses etc., the Ombudsman concluded his processing of the case.

Verbal recommendations to the institution's management

Body searching and urine sampling: Recommendations were given to the Prison and Probation Service to, among other things, increase the level of information to the inmates as well as the management's follow-up in connection with body searching and urine sampling. The management at a number of psychiatric institutions was recommended to adjust the information material and in-house instructions so that the information is in accordance with current rules.

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Forcible measures: At a number of institutions, the management was recommended to introduce, review or broaden instructions regarding forcible measures.

Pepper spray: At a number of Prison and Probation Service institutions, the management was recommended to ensure that the staff have the requisite authorisation when carrying pepper spray.

Coercion: A number of institutions were given recommendations about the contents of the systematic follow-up sessions after use of coercion in psychiatric care, including improvement of documentation in that respect.

Violence and threats: At a number of institutions, the management was recommended to introduce or broaden policies on violence and threats among the users.

Medicine management etc.: A number of Prison and Probation Service institutions and social services institutions were recommended to introduce or adjust instructions on medicine management etc. Moreover, a number of institutions were given recommendations regarding safekeeping of medicine, systematic examination of the medicine cupboard, focus on unintended incidents and the inmates' contact with the doctor.

Work and leisure time activities: Recommendations were given to a few institutions regarding opportunities for specific work and leisure time activities for the users, for instance to improve the users' access to the gym.

Placement in police detention facilities: At a few institutions, the management was recommended to improve the supervision of persons placed in police detention facilities for intoxicated persons, and a number of institutions were given recommendations about formal matters, including the documentation in detention reports.

MONITORING ACTIVITIES – CHILDREN

MONITORING VISITS, CHILDREN

No.	Date	Name and location of institution	DIGNITY participated	Danish Institute for Human Rights participated (IMR)	
1	12 January	'Afdeling for Børne- og Ungdomspsykiatri', Roskilde			
2	12 January	The school at 'Afdeling for Børne- og Ungdoms-psykiatri', Roskilde			
3		15-year-old girl held in solitary confinement	✓	✓	
4	22-23 February	'Børne- og Ungdoms-psykiatrisk Center', Bispebjerg Hospital, Copenhagen	✓	✓	
5	22-23 February	The school at Bispebjerg Hospital, Copenhagen	✓	✓	
6	14-15 March	'Børne- og Ungdomspsy-kiatrisk Center', Risskov			
7	14-15 March	The school at 'Børne- og Ungdomspsykiatrisk Center', Risskov			
8	24-25 May	'Børne- og Ungdoms-psykiatrisk Center', Glostrup Hospital		✓	

1) Number of children and young persons who had talks with the visiting teams.

2) Number of parents, patient advisors and personal representatives who had talks with the visiting teams.

	Talks with users[1]	Talks with relatives and others[2]	Type of institution and target group
	4	8	Three bed units for general psychiatric patients
	*	*	School with classes for hospitalised patients of compulsory school age
	1	0	Custody on remand in solitary confinement of underage child
	9	13	Three bed units for general psychiatric patients
	*	*	School with classes for hospitalised patients of compulsory school age
	3	3	Three bed units for general psychiatric patients
	*	*	School with classes for hospitalised patients of compulsory school age
	4	3	Four bed units for general psychiatric patients and one bed unit for both general psychiatric patients and patients with a disorder relating to forensic psychiatry

*) Talks with users and relatives and others at the psychiatric ward were also related to the school.

Continued next page

MONITORING VISITS, CHILDREN

No.	Date	Name and location of institution	DIGNITY participated	Danish Institute for Human Rights participated (IMR)	
9	24-25 May	The school at Glostrup Hospital		✓	
10	3-4 October	'Børne- og Ungdomspsykiatri Odense', Odense			
11	3-4 October	The school at 'Børne- og Ungdomspsykiatri Odense', Odense			
12	31 October - 1 November	Aalborg University Hospital, 'Psykiatrien', 'Klinik Børn og Unge', Aalborg	✓	✓	
13	31 October - 1 November	The School at 'Klinik Børn og Unge', Aalborg	✓	✓	
14	24-25 November	'Børnecenter Hundstrup', Vester Skerninge	✓	✓	
Total	**14** visits		DIGNITY participated in **6** visits	IMR participated in **8** visits	

	Talks with users[1]	Talks with relatives and others[2]	Type of institution and target group
	*	*	School with classes for hospitalised patients of compulsory school age
	2	4	One bed unit for general psychiatric patients
	*	*	School with classes for hospitalised patients of compulsory school age
	4	6	One bed unit for general psychiatric patients
	*	*	School with classes for hospitalised patients of compulsory school age
	13	2	Asylum centre for unaccompanied underage asylum seekers
	40 talks	**39** talks	

EXAMPLES OF IMPORTANT RESULTS

Themes

Every year, the Ombudsman selects a theme in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture for the monitoring visits carried out by the Children's Division.

You can learn more about the themes and read the thematic reports at www.ombudsmanden.dk (choose English) under 'Publications'.

THEME IN 2016: CHILDREN AND YOUNG PERSONS IN PSYCHIATRIC CARE WITH FOCUS ON

– immobilisation
– teaching
– involvement and participation in decision making

The Ombudsman's key conclusions and recommendations

– The Ombudsman found that children and young persons in psychiatric care were involved in the preparation of individual/personal strategies in order to prevent self-harm.

– The Ombudsman found that teaching was given priority as an important part of the children's and young persons' treatment, and that teaching was planned after consultation with the children and the young persons.

– There was a need for improvement of the wards' information to custodial parents that parents do not have to make a decision about the use of coercion or force against their children under the age of 15. The Ombudsman gave recommendations on this to all institutions/wards.

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Discussions with key authorities

Abuse: At a meeting, the Ministry for Children and Social Affairs and the National Board of Social Services stated that the Board had launched a number of initiatives in order to prevent sexual abuse at institutions for children and young persons with disabilities. The background for doing so was, among other things, the 'Anti-Abuse Package' in 2013 and the Ombudsman's general recommendation in a thematic report of 2015 to introduce guidelines on how institutions for children and young persons with disabilities prevent sexual abuse and which procedures the institutions should follow if they suspect abuse. The Board was working on a manual and had initiated an investigation which was carried out by the SFI – The Danish National Centre for Social Research.

IT aids: At a meeting with the Ministry for Children and Social Affairs and the National Board of Social Services, it was discussed whether there was a need to extend people's knowledge of the IT aids which support the communication for children and young persons with disabilities who have limited or no verbal language. The discussion was based on the Ombudsman's thematic report in 2015 about institutions for children and young persons with disabilities. The authorities stated that a knowledge portal about alternative communication aids will be launched and that IT aids will be included in a manual.

Health: During a meeting with the Danish Immigration Service, the Ombudsman asked whether the asylum centres were fully aware that children seeking asylum basically have the same rights to preventive health services and healthcare benefits as children residing in Denmark. The Danish Immigration Service indicated that they would follow up on this.

Use of force: During a meeting with the Danish Immigration Service, the Ombudsman asked how it is ensured that the asylum centres have knowledge of the rules

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on the use of force against children and young persons. The Danish Immigration Service said that they had discussed this issue with the centres and would now undertake further follow-up on this.

Cases (concluded in 2016) opened after monitoring visits

Action plans: Following monitoring visits, the Ombudsman took up a number of cases about the lack of action plans for children and young persons placed in care. Seven out of 13 cases were concluded with criticism. (The Ombudsman's Case No. 2016-44).

In-house schools: Following monitoring visits, the Ombudsman investigated the teaching at four in-house schools for children and young persons at placement facilities. The Ombudsman criticised that three schools did not provide teaching in the full range of subjects and that two schools did not observe the rule that pupils may only be exempt from classes in one or more subjects on the basis of a specific pedagogical and psychological evaluation of the individual pupil. Formal recommendation was given in two cases. (News item of 14 January 2016).

Supervision of teaching: Following monitoring visits, the Ombudsman investigated three municipalities' supervision of the teaching at in-house schools in placement facilities for children and young persons. One case was concluded with criticism. After being contacted by the Ombudsman, the Ministry of Education impressed on all municipalities the rules on teaching at in-house schools for children and young persons in placement facilities. Furthermore, the Ministry also emphasised that municipalities are required to supervise the teaching. (News items of 14 January and 23 December 2016).

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Verbal recommendations to the institution's management

Coercion: Psychiatric wards were recommended to ensure that information was always given to the custodial parent that parents do not have to make a decision about the use of coercion or force against their children under the age of 15. Some wards were recommended to make written information about this issue available.

Documentation: Psychiatric wards were recommended to be more careful to complete protocols on the use of coercive measures. It was also recommended that the ward makes sure to enter into the protocol the names of the staff participating in forced immobilisation.

Teaching: It was recommended at several places that the school at the psychiatric ward adjusted its practice so that teaching was planned after consultation with the parents. The schools were also recommended to ensure that the person in charge of the teaching during hospitalisation obtains information about the pupil's classes so far.

Involvement and participation in the decision-making: It was recommended to ensure that the patient is involved and consulted about the contents of the treatment plan and also consulted on advance directives. It was also recommended to ensure that follow-up sessions are offered to patients and parents who have consented to the treatment of their children under the age of 15.

Rights: Recommendations were given that the ward consider introducing material with information about the rights of children and young persons in psychiatric care which is written in a language aimed at children and young persons and possibly adapted to more than one age group.

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Use of force: One asylum centre was recommended to be aware that only the rules of the Danish Criminal Code on self-defence and *jus necessitas* apply in connection with the use of force – and not the rules of the Social Services Act.

Health: One asylum centre was recommended to ensure that its health service in future observes the rules, including that child asylum seekers basically have the same rights to preventive health care services and health care benefits as children residing in Denmark.

House rules: One asylum centre was recommended to have the house rules translated into other relevant languages than English. Psychiatric wards were recommended to consider whether the practice described in the house rules about compensation (according to which the ward could not be held liable for damages) was true and fair.

Residents' council: One asylum centre was recommended to assist the residents in setting up a residents' council.

Other results

The Danish Act on Adult Responsibility (voksenansvarsloven): In 2016, Parliament passed the bill on adult responsibility for children and young persons at a placement facility. The Act is to a great extent based on recommendations from the Committee on the Use of Force Towards Children and Young Persons at Placement Facilities. The Committee was set up after the Ombudsman had raised questions about the rules on the use of force on the basis of monitoring visits.

MONITORING ACTIVITIES DISABILITY ACCESSIBILITY

MONITORING VISITS ON ACCESSIBILITY

Where

The Ombudsman monitors the accessibility of public buildings, such as primary and lower secondary schools, educational institutions, town halls, libraries, hospitals and polling stations.

Why

At the request of Parliament, the Ombudsman monitors developments regarding equal treatment of persons with disabilities. In this connection, the Ombudsman monitors, among other things, the physical accessibility for persons with disabilities. The aim is to check that the rules ensuring that public buildings are accessible to everybody are observed.

How

During the monitoring visits, the Ombudsman's monitoring team will be shown round the buildings. The Ombudsman's monitoring team brings along measuring equipment to check, for example, whether ramps for wheelchair users have a degree of inclination which is in accordance with building regulations.

Who

The Monitoring Department carries out the monitoring of accessibility. A wheelchair user who works as a consultant for the Ombudsman participates in the monitoring visits. Furthermore, the Ombudsman's special advisor on children's issues has participated in monitoring visits to primary and lower secondary schools.

MONITORING VISITS ON ACCESSIBILITY IN 2016

Date	Name and location of institution	Type
30 March	'Brændkjærskolen', Kolding	Primary and lower secondary school with a specialist centre
28 September	'Rosengårdskolen', Odense	Primary and lower secondary school with a specialist section

EXAMPLES OF IMPORTANT RESULTS IN 2016

Outcome of the monitoring visits on accessibility

The monitoring visit on accessibility to 'Brændkjærskolen' resulted in a number of recommendations on parking, accessibility and signposting. The Ombudsman also recommended that – in connection with a future renovation – play areas are established which are made more accessible to pupils with a mobility impairment, and that a future renovation of the shower room and the sauna also includes a wider door and a lowering of the doorstep so that wheelchair users also can get access.

The case concerning the accessibility inspection at 'Rosengårdskolen' was still pending when the Annual Report was submitted.

In 2016, the Ombudsman also concluded a case about a monitoring visit on accessibility to 'Skovvangskolen' in Allerød which was carried out in 2015. The monitoring visit resulted in a number of recommendations, among other things about accessibility, signposting and shielding. Pursuant to the rules laid down in the UN Convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child, it was recommended to furnish the school's outdoor playground with play facilities for the school's pupils with various forms of mobility impairment.

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In addition to this, the Ombudsman also formally recommended that the school and Allerød Municipality at the very first opportunity ensure accessibility for pupils with a mobility impairment to the school's special subject rooms.

More information about the Ombudsman's work on equal treatment of persons with disabilities and the Ombudsman's reports on accessibility inspections can be found at www.ombudsmanden.dk/handicap (in Danish only)

Other activities

Accessibility of train stations for persons with disabilities: The case, which was taken up by the Ombudsman on his own initiative, was concluded in 2016 and comprised 13 long-distance and regional train stations around the country where the only access to the platform was via stairs from a tunnel or a bridge.

Based on a reply from the Ministry of Transport (now Ministry of Transport, Building and Housing), the Ombudsman found, among other things, that on 12 of the stations there were still significant obstacles as regards the accessibility for persons with mobility impairment. Installation of lifts or ramps at the 12 train stations could not be required under legislation, including the relevant EU legislation, but the Ombudsman considered it very important that the efforts to improve accessibility at train stations continue pursuant to the UN Convention on the Rights of Persons with Disabilities.

Meetings: The Ombudsman collaborates with the Danish Institute for Human Rights and the Danish Disability Council in order to facilitate, protect and monitor the implementation of the UN Convention on the Rights of Persons with Disabilities. As part of this collaboration, the Ombudsman held two meetings with these institutions in 2016.

MONITORING ACTIVITIES FORCED DEPORTATIONS

MONITORING OF FORCED DEPORTATIONS

What

The Ombudsman monitors forced deportations by the police of foreign citizens without legal residence in Denmark.

Why

The monitoring is especially aimed at ensuring that police activities are carried out with respect for the individual and without unnecessary use of force. Thus, the Ombudsman assesses whether the police act in accordance with current law – including EU law and international human rights conventions – and good administrative practice.

How

The monitoring covers the time from the decision on forced deportation until the deportation is completed.

The Parliamentary Ombudsman examines police reports and a number of concluded deportation cases. The Ombudsman's monitoring staff also participate in specific deportations.

The Ombudsman's monitoring is concentrated on the following focus areas: use of force, separation of families, vulnerable groups, for example persons with health problems, preceding contact and information, security assessment prior to the deportation, aborted deportations and the deportation report.

Who

The Monitoring Department carries out the monitoring of the forced deportations.

For more information about the Ombudsman's monitoring of forced deportations, please see www.ombudsmanden.dk/udsendelser (in Danish only).

FORCED DEPORTATIONS MONITORED IN 2016[1,2]

Date	Number of persons	Use of force?	Deportation completed?
8 February	1	Yes	Yes
17 February	4	No	Yes
20 March	1	No	Yes
13 April	1	No	No
14 June	1	Yes	No
6 September	1	Yes	No
13 September	4	Yes	Yes (partly)
14 September	1	Yes	Yes
22 September	1	Yes	Yes
18 October	2	No	Yes

1) Deportation of foreign nationals who do not depart voluntarily can either be carried out through a supervised departure, where the departure from the country is supervised by the police, for example when the foreign national boards a plane, or through an escorted departure where the police escort the foreign national out of the country to the foreign national's home country or a third country where the foreign national is entitled to take up residence. In 2016, all deportations monitored by the Ombudsman were escorted departures.

2) In 2016, the destinations of the deportations monitored by the Ombudsman were the following countries, among others: Tunisia, Nigeria, Afghanistan, Libya, Japan, the Democratic Republic of Congo and China.

Comments
Forced deportation by scheduled flight of a 31-year-old man. Force was used in the form of restraint belt with tied hands. The forced deportation was only partly monitored by an Ombudsman legal case officer, since the monitoring was carried out from the time when the police picked up the foreign national until boarding at the airport.
Forced deportation of three men aged 23-32 years and a 40-year-old woman. The forced deportation was partly organised by the EU border control agency, Frontex.
Forced deportation by scheduled flight of a 32-year-old man.
Forced deportation by scheduled flight of a 26-year-old man.
Forced deportation by scheduled flight of a 69-year-old man. Force was used in the form of a bodycuff[3] with tied hands and manual restraint.
Forced deportation by scheduled flight of a 37-year-old man. Force was used in the form of manual restraint and a bodycuff with tied arms and hands and with limited mobility of one leg. The case was still pending when the Annual Report was submitted.
Forced deportation by chartered plane of a 21-year-old man and a family consisting of a 31-year-old man, a 29-year-old woman and a three-year-old son. Force was used against the 21-year-old man in the form of manual restraint, a helmet and bodycuff with tied arms, hands and legs. Force was used against the 31-year-old man in the form of manual restraint, helmet and a bodycuff with tied hands. Force was used against the 29-year-old woman in the form of manual restraint and a bodycuff with tied hands. The case was still pending when the Annual Report was submitted.
Forced deportation by scheduled flight of a 42-year-old woman. Force was used in the form of manual restraint and a bodycuff with tied hands. In addition to this, the woman had to wear an adult diaper. The forced deportation was only partly monitored by an Ombudsman legal case officer since the monitoring was carried out from the time when the police picked up the woman until boarding at the airport. The case was still pending when the Annual Report was submitted.
Forced deportation by scheduled flight of a 26-year-old man. Force was used in the form of manual restraint. The forced deportation was only partly monitored by an Ombudsman legal case officer, since the monitoring was carried out from the time when the police picked up the foreign national until boarding at the airport.
Forced deportation by scheduled flight of a 58-year-old man and a 60-year-old woman.

3) A bodycuff is a type of restraint belt where wrists, arms, knees and ankles can be restrained by means of Velcro closure/click lock.

EXAMPLES OF IMPORTANT ACTIVITIES IN 2016

Specific deportations

In 2016, the Ombudsman monitored 10 forced deportations of foreign nationals. In none of the seven cases concluded in 2016 did the Ombudsman criticise the police work. The Ombudsman assessed that the deportations were carried out according to Danish and international guidelines, with respect for the individual and without unnecessary use of force. In addition to this, the Ombudsman did not have any comments on the documentation of the cases. Three deportation cases were pending when the Annual Report was submitted.

Discussions

In 2016, the Ombudsman had dialogue meetings with the National Police, 'Nationalt Udlændingecenter' (NUC – National Immigration Centre), North Zealand Police and 'Udlændingecenter Nordsjælland' (North Zealand Immigration Centre) about the Ombudsman's monitoring of forced deportations carried out by the police. In addition to this, meetings have also been held with the Danish Refugee Council and the then Ministry of Immigration, Integration and Housing.

International collaboration

In 2016, the Ombudsman participated in two European workshops on forced deportations. The Ombudsman also attended a European course on monitoring of forced deportations.

SUMMARIES OF SELECTED STATEMENTS – RELATING TO MONITORING ACTIVITIES

The Ombudsman regularly publishes statements (in Danish) on certain types of cases on www.ombudsmanden.dk and on www.retsinformation.dk, the official legal information system of the Danish state.

Summaries are provided below (by ministerial area[1]) of the statements published on cases concluded in 2016 which related to monitoring activities.

G. MINISTRY OF JUSTICE

2016-18. Rules on use of force, use of handcuffs and placement in security cells in halfway houses under the Prison and Probation Service

During a monitoring visit to a halfway house under the Prison and Probation Service, the Ombudsman's visiting team learnt that a dog handler with the Department of the Prison and Probation Service and the manager of the halfway house had used force and handcuffs on a resident. The Corrections Act contains provisions authorising this. However, the Department had issued rules which in the Ombudsman's opinion were unclear regarding whether the use of force and handcuffs was authorised in halfway houses. The Ombudsman therefore asked the Department if the use of force and handcuffs on the resident was authorised.

The Department of the Prison and Probation Service informed the Ombudsman that there was no basis for permitting halfway house staff to use force under the Corrections Act as – unlike, for instance, dog handlers – they had not been trained in this. The Department issued new rules, which included a distinction between Department staff and halfway house staff.

In a preliminary report, the Ombudsman stated that there were still some unclear points in the rules, and that he intended to recommend that the rules be amended. He also stated that he assumed that halfway house staff received adequate instruction in conflict management and the use of force. In addition, he commented on section 13(3) of the Criminal Code.

1) The summaries have been classified under the ministries which had the remit for the relevant areas at the end of the year.

Following a meeting with the Ombudsman, the Department informed the Ombudsman that the rules would be amended. Among other things, clear directions would be issued to halfway house staff.

On that basis, the Ombudsman concluded the case. He pointed out that he assumed that halfway house staff were kept up-to-date on conflict management etc. In addition, he clarified the comments on section 13(3) of the Criminal Code which he had made in his preliminary report.

The Department of the Prison and Probation Office subsequently informed the Ombudsman that the amended rules would come into force on 1 May 2016.

2016-21. Monitoring visits to police detention facilities for intoxicated persons

The Ombudsman made two unannounced monitoring visits at night to the detention facilities for intoxicated persons of two police stations in Copenhagen. The monitoring visits, which were carried out in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture, focused especially on the safety of persons placed in detention facilities, health issues, use of force and other restrictions and the rights of persons placed in detention facilities.

After the visits, the Ombudsman assessed the case material of eight cases about placement in detention facilities. The Ombudsman's assessment of the cases showed that in general, the police documentation in the cases was inadequate. For instance, it had not been sufficiently documented in all cases that the police had checked as stipulated on the persons placed in the detention facilities or that the persons had been given guidance about the possibility of complaining about the police.

Copenhagen Police and the National Police expressed their regrets and at the same time initiated a number of measures to avoid similar inadequacies occurring in other cases. The Ombudsman agreed with the police that it was regrettable that the documentation in the cases was inadequate. He noted the information from the police about measures to ensure improvements and pointed out that during future monitoring visits to detention facilities for intoxicated persons, he would follow up on the issues raised by his visits to the two facilities.

2016-52. Use of force in local prison inadequately investigated

During a monitoring visit by the Ombudsman to a local prison, a number of inmates told the visiting team of an incident in which an inmate was pushed several times by a prison guard. The Ombudsman learnt that the prison management were not aware of the incident and for this reason had not looked into it. The Ombudsman asked the management for a statement on the matter and subsequently opened an investigation on his own initiative.

The Ombudsman found that several aspects of the authorities' investigation and assessment of whether illegal force had been used by staff of the local prison were matters for criticism.

Among other things, the Ombudsman criticised that the authorities did not investigate the incident further until after the video surveillance recordings had been deleted and that it was more than four months before the authorities sought to get accounts of the incident from the other inmates who had witnessed it.

In his statement, the Ombudsman referred to the ex officio investigation principle in Danish administrative law and to international norms and standards regarding investigation of information about mistreatment of persons deprived of their liberty.

2016-56. Greatly improved conditions at Vridsløselille after monitoring visit

A visiting team consisting of representatives from the Ombudsman's office and experts from the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture made an unannounced monitoring visit in February 2016 to Vridsløselille, a former prison where detained foreign nationals are now placed. They have been detained to ensure their availability, for instance when they are to leave the country or when their asylum case is to be considered – they are not there to serve a sentence for a criminal offence. The Ombudsman had been tipped off about the conditions at Vridsløselille by Amnesty International and a doctor.

The visiting team noted that the persons detained at Vridsløselille were locked up in small prison cells almost around the clock, that there was a lack of leisure and work activities and that communication and information were inadequate.

Thus, several of the foreign nationals did not know why they had to be in prison, and the staff had not received sufficient information and training to take care of them. The Ombudsman wrote to the responsible authorities that he was seriously concerned about the foreign nationals at Vridsløselille. The Department of the Prison and Probation Service agreed that the conditions at Vridsløselille were problematic and informed the Ombudsman that a number of changes and improvements were in the pipeline.

During a new visit in June 2016, it was evident to the visiting team that many aspects of the conditions at Vridsløselille had been greatly improved. Thus, the persons detained there were now able to move around communal areas and spend time with each other there in the daytime, and more leisure and work activities were available. However, the persons were still locked up in their cells from the evening until the morning and during some periods of time in the daytime, meaning that they were locked up for a total of more than 12 out of 24 hours. The Ombudsman asked for the reason for this. He compared this aspect of the conditions at Vridsløselille to the conditions at Ellebæk, another facility for detained foreign nationals, where the persons detained had greater freedom, and mentioned that also the availability of work activities differed between the two facilities.

The Department of the Prison and Probation Service subsequently reported that it had been decided that persons detained at Vridsløselille were no longer to be locked up at night and that efforts were being made to increase the availability of work activities. In November 2016, the Department informed the Ombudsman that since 1 October 2016, work had been available to all those detained at Vridsløselille. In addition, they could sleep two in a cell if they wished. The Ombudsman concluded the case, remarking that he assumed the authorities would continue to be attentive to the conditions for the foreign nationals detained at Vridsløselille.

N. MINISTRY OF TRANSPORT, BUILDING AND HOUSING

2016-40. Accessibility of train stations to persons with disabilities

In a number of replies to Parliament, the then Ministry of Transport had stated that there were 13 long-distance and regional train stations around the country at which the platforms could only be accessed via stairs from a tunnel or a bridge. On that basis, the Parliamentary Ombudsman asked the Ministry whether, and if so how, persons with mobility disabilities could use these stations, whether

there were plans for improvements in their accessibility and how users were informed about the means of access.

Based on the Ministry's answers to his questions, the Ombudsman noted that at 12 of the 13 long-distance and regional train stations, there are still considerable obstacles to accessibility for persons with mobility disabilities.

Although installation of lifts or ramps at the 12 train stations cannot be required under legislation, including the relevant EU legislation, the Ombudsman considers it very essential that efforts to improve the accessibility of train stations continue in keeping with the UN Convention on the Rights of Persons with Disabilities and other provisions. However, he acknowledges that this can be costly.

The Ombudsman's recommendations included that the responsible authorities consider providing level-free access to the platforms at those of the stations where there were no current plans of installing lifts.

T. MUNICIPAL AND REGIONAL AUTHORITIES ETC.

2016-16. Monitoring visit to investigate physical accessibility of primary and lower secondary school to persons with disabilities

The Parliamentary Ombudsman made a monitoring visit to a primary and lower secondary school to investigate its accessibility to persons with disabilities. During his monitoring visit and in his preliminary report, the Ombudsman recommended a number of initiatives to improve the school's accessibility to persons with disabilities. The school and the municipality subsequently stated in a reply to the Ombudsman which measures would be taken on that basis.

The Ombudsman's recommendations related to aspects such as the school's play facilities for children with mobility disabilities, the accessibility of its special subject rooms to these pupils and the school's practice with regard to exempting pupils from certain subjects on account of their disabilities.

In his final report to the school and the municipality, the Ombudsman reiterated several recommendations and asked to be notified of the further process in relation to a few of his recommendations. The Ombudsman referred to provisions in the UN Convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child as his basis for several recommendations.

2016-32. Forensic psychiatric ward had no authority to forbid patients to buy unhealthy food

Following press coverage of patients in a special forensic psychiatric ward (Sikringsafdelingen) being restricted in their choice of food, sweets and soft drinks, the Ombudsman raised the case with the Region Zealand.

The forensic psychiatric ward explained that certain types of medicine carry an increased risk of obesity, and that in order to prevent the adverse health effects of obesity, the ward tried to get patients to adopt a healthier lifestyle. Where it was not possible to get patients to do so voluntarily, the ward had restricted their possibilities of buying unhealthy foods such as sweets, pizza and burgers.

The Ombudsman was understanding of the ward's efforts to help those patients who could not be motivated to change their behaviour. At the same time, however, he stated that restrictions on patients' right of self-determination require legal authority. As there was no legal authority for this particular restriction on the right of self-determination, the ward was not entitled to impose restrictions on the individual patients' right to buy unhealthy food. The Ministry of Health agreed with the Ombudsman's assessment.

As these patients' health situation was to some degree a consequence of the treatment which they were (forcibly) receiving, and as there were medical grounds for intervening in relation to their health situation, the Ombudsman assumed that the authorities would consider whether the forensic psychiatric ward had the necessary possibilities for helping these patients in a reasonable and safe manner.

2016-44. Failure of municipality to provide placement facility with copies of relevant parts of action plan for child

If an action plan for a child or a young person involves his or her being placed in a facility of one of the types listed in section 66 of the Social Services Act, the facility must be provided with copies of relevant parts of his or her action plan. This is provided by the Act's section 140(7), which came into force on 1 January 2014.

During a monitoring visit to a therapeutic residential facility for children with special needs, the Ombudsman's visiting team were informed that the facility had not received copies of parts of the action plan for one of the children in the facility from her municipality.

The girl had moved into the facility before the provision on municipalities' obligation to provide placement facilities with copies of relevant parts of action plans came into force.

The Ombudsman stated that there was no specific basis for construing the provision on the obligation restrictively as not applying to children and young people who had already been placed in a facility. In addition, the Ombudsman was of the opinion that the purpose of the provision indicated that it also applied to children and young people placed in facilities before 1 January 2014.

On that basis, the Ombudsman was of the opinion that the girl's municipality should have provided the facility in which the girl had been placed with copies of relevant parts of her action plan after section 140(7) of the Social Services Act came into force on 1 January 2014.

2016-50. Recommendation for National Board of Social Services to consider training of staff of social care accommodation facilities in use of force

The Ombudsman's investigation of a specific case in which a young man in a social care accommodation facility died in connection with force being used on him occasioned the Ombudsman to raise the question whether authorities which operate social care institutions are required to ensure that general guidelines on the use of force are drawn up to the extent relevant.

The case also caused the Ombudsman to raise the question whether the authorities in question are required to ensure that social care institution staff receive adequate training in the use of force.

The Ombudsman asked the National Board of Social Services to consider the two questions.

2016-58. Distinction between preventive measures and special measures relating to children and young people (sections 11 and 52 of Social Services Act)

After receiving two anonymous letters about the situation in a municipality's children and families department, the Ombudsman opened a case with the municipality. The anonymous letters firstly concerned the duration of the municipality's preventive measures relating to children, young people and

families under section 11(3) of the Social Services Act. The letters stated that in a large number of difficult cases, the municipality's three advisory teams had been using preventive measures 'for months and years' without initiating child protection examinations and preparing action plans. Secondly, it was stated that the processing times of the municipality's examination team were very long for child protection examinations under section 50 of the Social Services Act.

In his statement on the case, the Ombudsman explained section 11(3) of the Social Services Act on preventive measures and section 52 on special measures: section 11 is a provision on actual preventive measures and is aimed at children and young people with delimited problems, whereas section 52 is aimed at children and young people with problems of such a complex nature that a child protection examination is needed in order to determine their need for special measures.

Based on information received from the municipality, the Ombudsman criticised that the municipality had used preventive measures under section 11(3) of the Social Services Act in a number of cases where it should have made a decision to implement provisional support under section 52(2), cf. subsection (3), of the Act. However, because of information which he had received from the municipality about organisational changes, the Ombudsman took no further action in relation to the duration of the preventive measures.

The Ombudsman further stated that in his opinion it was a matter for severe criticism that during some periods in the years 2013 to 2015, the processing times for child protection examinations had exceeded the time limit of four months specified by the Social Services Act in more than half of all cases. The Ombudsman asked the municipality for further information about its processing times for child protection examinations in 2016.

NEWS – RELATING TO MONITORING ACTIVITIES – PUBLISHED ON THE OMBUDSMAN'S WEBSITE IN 2016

All news can be read in full (in Danish only) on www.ombudsmanden.dk.

14 January

Children placed in care outside their home entitled to lessons in all primary and lower secondary school subjects

Children and young people who are placed in care outside their home and are taught in an in-house school of a residential facility or an institution have the same right to education as pupils in ordinary primary and lower secondary schools. However, following monitoring visits to placement facilities for children and young people in care, the Ombudsman became aware that several in-house schools did not provide sufficient education. In one school, pupils only had lessons in the core subjects of Danish, mathematics and English.

4 February

Staff of Ombudsman's Children's Division visit 15-year-old girl held in solitary confinement

Staff of the Ombudsman's Children's Division have, together with representatives of the Institute for Human Rights and DIGNITY – Danish Institute Against Torture, visited a 15-year-old girl who has been in solitary confinement since 14 January 2016. It is extremely rare for minors to be held in solitary confinement.

8 February

Ombudsman's Children's Division to focus on children and young people in psychiatric wards

In 2016, staff of the Ombudsman's Children's Division are going to visit a large proportion of children and young people in psychiatric wards as the theme for this year's monitoring visits by the Children's Division is residential psychiatric wards. One of the central issues is the use of forced immobilisation on children and young people.

15 March

Ombudsman seriously concerned about foreign nationals detained at Institution of Vridsløselille

Following an unannounced monitoring visit to the Institution of Vridsløselille on 29 February 2016, the Ombudsman is seriously concerned about the conditions for detained foreign nationals.

29 March

Police will improve documentation in connection with deportations

The National Police is now going to develop a form to be completed by police in order to ensure that all relevant processing steps in cases of forced deportations of foreign nationals are documented sufficiently. The form will be a supplement to the deportation reports which are prepared by the police today.

This initiative is being introduced after the Parliamentary Ombudsman has on several occasions pointed out insufficient documentation in relation to deportations.

8 April

Primary and lower secondary schools must ensure children with disabilities equal access to play and education

According to the UN Convention on the Rights of Persons with Disabilities, children in Danish primary and lower secondary schools who have mobility disabilities must have equal access with non-disabled children to participation in education, play and leisure activities. Therefore, it is important that this is promoted and encouraged by the physical facilities of schools. This is the conclusion following a monitoring visit by an Ombudsman team to investigate the physical accessibility of a school in Allerød Municipality to persons with disabilities.

25 April

Major differences in utilisation of communication aids for children and young people with considerable disabilities

During the past year, the Ombudsman's Children's Division has made monitoring visits to a number of institutions for children and young people with considerable disabilities and almost no language. The overall conclusion is positive, but the Ombudsman points out, among other things, that there are major differences in how good the institutions are at utilising the technological aids that exist in their communication with the children and young people.

27 April

Ombudsman announces new visit to Institution of Vridsløselille

Following information from the Prison and Probation Service that improvements in conditions for the foreign nationals who are detained at the Institution of Vridsløselille are in the pipeline, the Ombudsman has now announced a new monitoring visit to the Institution on 22 June 2016.

13 May

Prisons should tighten up on their use of security cells

In several cases, the Ombudsman has suspected illegitimate use of security cells and forced immobilisation when visiting state and local prisons and reviewing reports on placements in security cells. For this reason, the Ombudsman has now recommended that the Prison and Probation Service tighten up in a number of respects.

17 May

Institutions may be precluded from helping vulnerable citizens

The behaviour of some citizens who suffer from mental illness or have mental disabilities causes such problems that they cannot be dealt with in ordinary accommodation facilities for people with mental illness or disabilities. For this reason, they live in special accommodation facilities referred to as 'individual support programmes' with staff around the clock.

Following monitoring visits in 2015 to 14 institutions with a total of 79 individual support programmes, the Parliamentary Ombudsman concludes that conditions are generally good. However, in a number of serious situations, staff are unable to help the residents because they are not permitted to use coercion. (...)

26 May

Police promise tighter procedures in detention facilities for intoxicated persons

Two unannounced visits by the Ombudsman will now lead to improved procedures in Copenhagen detention facilities for intoxicated persons.

22 June

Municipalities may place children of asylum seekers etc. in care against parents' or guardians' wishes

Who is to help a child of asylum seekers or foreign nationals without legal residence in Denmark who is, for instance, neglected by his or her parents?

Is it the municipality, which has specialist knowledge of children, or is it the immigration authorities, under which matters relating to asylum seekers and foreign nationals without legal residence in Denmark normally belong? This question has given rise to confusion for a lengthy period of time.

The Ombudsman has carried out an investigation of the question (...).

20 September

Greatly improved conditions for foreign nationals detained at Vridsløselille

Following the Ombudsman's two monitoring visits and his dialogue with the responsible authorities, the conditions for the foreign nationals who are detained at Vridsløselille have been greatly improved.

14 October

People with disabilities precluded from travelling by train in several places

Under the UN Convention on the Rights of Persons with Disabilities, people with mobility disabilities must have access, on an equal basis with others, to public transportation. However, the Ombudsman notes that this is not always the case today, after receiving answers from the Ministry of Transport and Building to a number of questions about the accessibility of 13 long-distance and regional train stations in Denmark to people with disabilities.

16 November

Ombudsman recommends that authorities consider training of staff of social care accommodation facilities in use of force

In a social care accommodation facility in eastern Jutland, a young man died last year after being restrained by three staff members. None of the staff of the facility had received any actual training in the use of force.

The Ombudsman's investigation of the case shows, among other things, that there are no rules on training in the use of force in social care institutions.

17 November

Ombudsman's Children's Division to visit centre for unaccompanied underage asylum seekers

At the end of the month, a team from the Ombudsman's Children's Division is due to make the institution's first monitoring visit to a centre for unaccompanied asylum seekers under 18 years.

The visit to the centre – Børnecenter Hundstrup on the island of Funen – will take place in the wake of several cases concerning children in asylum centres which have been covered by the media. However, the visit has no direct connection to these cases, Susanne Veiga, head of the Ombudsman's Children's Division, explains.

23 November

Children placed in care outside their home do not always have an action plan

Municipalities are required to prepare action plans for children and young people placed in care outside their home. In addition, municipalities are required to provide the facilities in which the children or young people are placed with copies of relevant parts of their action plans. However, this is not always done, the Ombudsman notes following monitoring visits by the Ombudsman's Children's Division to a number of 24-hour residential institutions for children in care.

21 December

Allegations of illegal use of force must be investigated thoroughly

During a monitoring visit by the Ombudsman to a local prison, several inmates told the visiting team, independently of each other, of an incident in which a prison guard had got into a rage and, among other things, pushed an inmate down a corridor. The prison management and the Department of the Prison and Probation Service did not investigate the incident in depth before the video surveillance recordings were deleted.

The Ombudsman emphasises that any genuine suspicion of the use of illegal force in local and state prisons must be taken seriously and investigated.

23 December

Ministry stresses obligation to provide sufficient education to children placed in care outside their home

Children and young people who are placed in care outside their home have the same right to education as children and young people living at home. This has now been stressed to all municipalities of the country.

This is a result of the Ombudsman's Children's Division revealing that several in-house schools of residential facilities and institutions did not provide sufficient education – and contacting the Ministry of Education to ensure the proper functioning of municipalities' supervision of the education provided by in-house schools.

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