THE OMBUDSMAN'S 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 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 in a dignified, respectful manner 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. Pursuant to this Protocol, the Ombudsman has been appointed 'national preventive mechanism'. The task is carried out in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture that contribute with human rights and medical expertise.

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

How

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

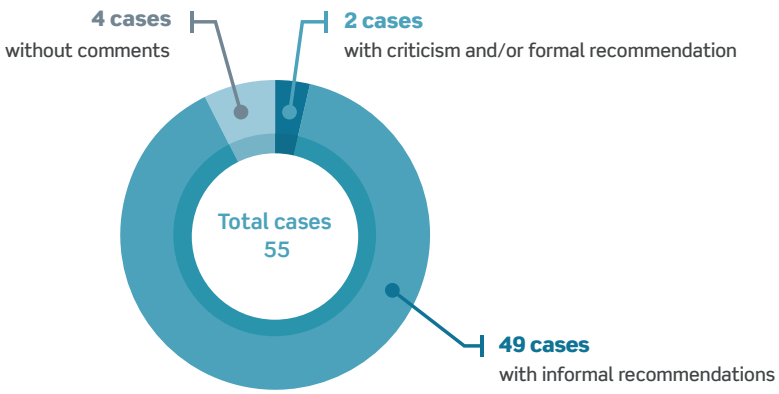
Monitoring visits may also give the Ombudsman cause to investigate general problems.

Who

The Monitoring Department also 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.

DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights participate in some of the visits.

MONITORING CASES CONCLUDED IN 2015



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

7 monitoring-related cases taken up by the Ombudsman on his own initiative. No cases resulted in criticism.

14 cases about suicide attempts, deaths etc. at the Danish Prison and Probation Service institutions. Criticism was expressed in 1 case.

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

10 monitoring-related cases taken up by the Ombudsman on his own initiative. Criticism was expressed in 5 cases.

International activities

In 2015, two meetings were held with representatives from the other Nordic national preventive mechanisms, and five meetings were held with representatives from other foreign ombudsman institutions with discussion and exchange of experiences about the OPCAT work.

The Ombudsman also held meetings about the OPCAT work with representatives from the UN Committee against Torture (CAT) and the UN Subcommittee on Prevention of Torture etc. (SPT).

MONITORING ACTIVITIES – ADULTS

MONITORING VISITS, ADULTS

No.	Date	Institution	DIGNITY participated	Danish Institute for Human Rights participated (IMR)	
1	16 January	The local prison in Elsinore	✓		
2	19-20 January	Århus University Hospital, forensic psychiatric ward in Risskov	✓	✓	
3	26 January	The local prison in Hobro			
4	27 January	The local prison in Århus		✓	
5	18-19 February	'Anstalten ved Hersted-vester'	✓		
6	5 March	The local prison in Køge			
7	18 March	The local prison in Esbjerg	✓		
8	19 March	The local prison in Kolding	✓		
9	19 March	The local prison in Aalborg			
10	20 March	The local prison in Frederikshavn			

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.

	Talks with users[1]	Talks with relatives and others[2]	Type of institution and target group
	7	0	Local prison, especially for remand prisoners during investigation of their case
	23	6	Four bed units for forensic psychiatric patients
	4	0	Local prison, especially for remand prisoners during investigation of their case
	4	0	Local prison, especially for remand prisoners during investigation of their case
	41	0	Closed prison for inmates who need psychological or psychiatric treatment
	4	0	Local prison, especially for remand prisoners during investigation of their case
	4	0	Local prison, especially for remand prisoners during investigation of their case
	6	0	Local prison, especially for remand prisoners during investigation of their case
	5	0	Local prison, especially for remand prisoners during investigation of their case
	5	0	Local prison, especially for remand prisoners during investigation of their case

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MONITORING VISITS, ADULTS

No.	Date	Institution	DIGNITY participated	Danish Institute for Human Rights participated (IMR)	
11	25 March	'Damsgaarden' in Gilleleje		✓	
12	9 April	Udviklingscentret 'De 2 Gårde' in Børkop			
13	10 April	'Birkekrattet' in Esbjerg			
14	28 April	'Atterbakken' in Tappernøje	✓	✓	
15	29 April	'CAS 2' in Copenhagen	✓	✓	
16	18 May	'Psykiatrisk Center Glostrup'[5]	✓		
17	19-20 May	'Sødisbakke' in Mariager			
18	3-4 June	'Landsbyen Sølund' in Skanderborg			
19	8 June	'Psykiatrien Vest' in Holbæk			

3) At a number of monitoring visits throughout the year in relation to customised projects for individuals, the users' level of function made talks impossible.

4) See page 85 about this year's theme with regard to the so-called customised projects for individuals.

5) The visit was carried out under the direction of Henrik Bloch Andersen, High Court Judge, as ad hoc Ombudsman, because the Ombudsman declared himself disqualified.

	Talks with users[1]	Talks with relatives and others[2]	Type of institution and target group
	0[3]	2	Customised project[4] for one individual in a private accommodation and day-care facility for adults with autism spectrum disorders, mental handicap and related disruptive behaviour disorder
	3	2	Customised projects for five individuals in a municipal accommodation facility for citizens with a mental handicap combined with, for example, psychiatric or social problems
	1	2	Customised project for one individual in a municipal accommodation facility for mentally handicapped persons requiring staff coverage day and night
	1	2	Customised project for one individual in a private socio-educational accommodation facility for vulnerable adults
	0[3]	1	Customised projects for three individuals in a municipal accommodation facility for mentally handicapped persons requiring predictability, structure etc.
	7	2	Three bed units for patients with a disorder relating to forensic psychiatry
	3	5	Customised projects for 25 individuals in a regional accommodation facility for adults with considerable and permanently diminished mental functional capacity
	4	8	Customised projects for eighteen individuals in a municipal accommodation and activity facility for adults with considerable and permanently diminished mental and physical functional capacity
	3	1	Two bed units primarily for general psychiatric patients

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MONITORING VISITS, ADULTS

No.	Date	Institution	DIGNITY participated	Danish Institute for Human Rights participated (IMR)	
20	8 June	'Regionspsykiatrien Viborg-Skive' in Viborg			
21	9 June	The local prison in Nykøbing Mors			
22	17 June	'Solkrogen' in Klim			
23	18 June	'Skovbrynet' in Brønderslev			
24	30 June	'Pension Skejby' in Århus			
25	1 July	Psychiatric ward in Vejle			
26	27 August	'Ørum Bo- og Aktivitets-center'			
27	28 August	'Hyldgården' in Holstebro			
28	28 August	'Institutionen Ellebæk' in Birkerød (**unannounced** visit)	✓	✓	
29	2 September	'Stokholtbuen' in Herlev		✓	

	Talks with users[1]	Talks with relatives and others[2]	Type of institution and target group
	7	10	Two regional bed units for patients with a disorder relating to forensic psychiatry
	2	0	Local prison, especially for remand prisoners during investigation of their case
	0[3]	1	Customised projects for three individuals in a municipal accommodation facility for adults with considerably diminished physical or mental capacity combined with disruptive behaviour disorder
	2	3	Customised projects for six individuals in municipal accommodation facility for mentally handicapped adults with special needs – often with violent or self-harming behaviour
	3	0	Prison and Probation Service institution for persons serving a sentence (typically in a social re-entry phase), remand prisoners serving alternatively and persons with no criminal record
	2	1	Two bed units for general psychiatric patients and patients with a disorder relating to forensic psychiatry
	0[3]	5	Customised projects for three individuals in municipal accommodation and activity facility for adults with special needs
	0[3]	3	Customised projects for three individuals in municipal accommodation facility for adults with permanently diminished physical and mental functional capacity
	13	0	Closed Prison and Probation Service institution for asylum seekers who are deprived of their liberty in accordance with the rules laid down in the Aliens Act
	1	1	Customised projects for six individuals in municipal accommodation and activity facility especially for adults with autism spectrum disorders

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MONITORING VISITS, ADULTS

No.	Date	Institution	DIGNITY participated	Danish Institute for Human Rights participated (IMR)	
30	9-10 September	'Statsfængslet på Kragskovhede' in Jerup	✓	✓	
31	17 September	'Rønnegård' in Gørløse			
32	21 September	'Solvognen' in Højby			
33	23-24 September	The state prison 'Statsfængslet i Ringe'	✓	✓	
34	3 October	The detention facility at 'Station City' in Copenhagen (**unannounced** visit)	✓	✓	
35	3 October	The detention facility at 'Station Bellahøj' in Copenhagen (**unannounced** visit)	✓	✓	
36	7 October	The police short-term holding facility at Copenhagen Airport in Kastrup (**unannounced** visit)	✓		
37	21 October	The state prison 'Statsfængslet Østjylland' in Horsens	✓	✓	
38	22 October	The state prison 'Statsfængslet Midtjylland' in Nr. Snede	✓	✓	
Total	**38** visits		DIGNITY participated in **16** visits	IMR participated in **13** visits	

	Talks with users[1]	Talks with relatives and others[2]	Type of institution and target group
	16	0	Open prison for persons serving a sentence
	2	4	Customised projects for three individuals in a regional accommodation facility for adults with a mental handicap, possibly combined with psychiatric disorders
	1	0	Customised project for one individual in a private residence facility for, among others, young people with considerable difficulties and a need for an individually adapted treatment
	16	0	Closed prison primarily for persons under the age of 24 serving a sentence, including a prison section for women
	0	0	Police detention facility especially for persons who are unable to care for themselves due to drug intoxication and 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 drug intoxication and have been encountered by the police in a dangerous situation
	0	0	Three short-term holding facilities especially used for short detention purposes for persons under arrest awaiting further interrogation
	8	0	Three closed prison sections especially for persons serving a sentence, including a deportation section and a high-security section
	21	0	Closed prison section for persons serving a sentence, including punitive and isolation sections
	219 talks with users	**59** talks with relatives and others	

EXAMPLES OF IMPORTANT REACTIONS IN 2015

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.

Thematic reports are published at www.ombudsmanden.dk.

THEME: Placement in solitary confinement cell

The Ombudsman's key recommendations

- State prisons and local prisons must ensure that inmates are only placed in solitary confinement cell and, if required, only forcibly restrained when deemed necessary.
- During placement, the staff must on a regular basis assess whether there are grounds for maintaining the placement and possibly immobilisation.
- The institutions must increase their focus on documentation in connection with placement in solitary confinement cell, and they must ensure that all reports on placement in solitary confinement cells contain a sufficient description of why it is necessary to use solitary confinement cell and possibly immobilisation.

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THEME: Customised projects for individuals[1]

The Ombudsman's key conclusions

- In general, the conditions and efforts for the target group of the customised projects were good.
- The visits shed light on a number of dilemmas, particularly about the balance between force and care.

Verbal recommendations to the institution's management

Placement in solitary confinement cell: Recommendation was given to many institutions to increase their focus on documentation and follow-up in connection with placement in solitary confinement cell. See the above theme about placement in solitary confinement cell.

Use of force: A number of institutions were recommended to prepare/revise an instruction about the use of force and to systematically review and assess statistical information about the use of force and other measures – including that the institution compares itself with other, similar institutions.

Coercion: A number of institutions were recommended to review and assess statistical information about the use of coercion in the mental health care system – including that the institution compares itself with other, similar institutions.

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1) The term 'customised projects for individuals' is used as a general term for special accommodation facilities for citizens with a behaviour which causes such problems that it cannot be dealt with at, for example, ordinary specialised accommodation facilities.

Violence and intimidation: A number of institutions were recommended to introduce a policy regarding violence and threats among the users and/or to follow the development in the cases involving violence and threats of violence systematically.

Medicine management: Recommendation was given to a number of Prison and Probation Service institutions and social sector institutions to prepare/update instructions about medicine management and/or introduce systematic registration and disposal, including to keep records of possible waste.

Work and leisure time activities: Recommendations regarding opportunities for specific work and leisure time activities were given to a few institutions.

Visiting rooms: Recommendations were given to a few institutions on the design of visiting rooms.

Local guidelines: A number of institutions were recommended to change the local guidelines, including rules of conduct, when the guidelines were either imprecise or not in compliance with current rules.

Discussions with key authorities

Health service in the Prison and Probation Service institutions: During his annual meeting with the Department of the Prison and Probation Service, the Ombudsman followed up on previous discussions about the health service available to the inmates at Prison and Probation Service institutions. After the meeting, the Prison and Probation Service has initiated a major investigation in order to determine how the Prison and Probation Service can organise and support the health service in the best possible way to ensure an equal and efficient conduct of the task. The Ombudsman is following the work.

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Own-initiative cases and requests for statements

Placement in solitary confinement cell: During a monitoring visit to a prison, the Ombudsman received information about a placement in a solitary confinement cell which had lasted approximately 3.5 days. After the visit, the Ombudsman took up a case with the Department of the Prison and Probation Service. The case is pending.

Information about use of force in connection with placement in a solitary confinement cell, which the Ombudsman received during a monitoring visit to another prison, resulted in the Ombudsman taking up a case with the prison. The case is pending.

Alarm/door-opener: Following a monitoring visit to a municipal accommodation facility, the Ombudsman took up a case regarding an alarm/door-opener which was installed for a citizen in a customised project. The case was concluded with criticism.

Use of special harnesses etc.: A monitoring visit to a municipal accommodation facility raised doubt about the facility's authority to use various types of harnesses and other protective measures towards a citizen who participated in a customised project. The Ombudsman took up two cases with the municipality. The cases are pending.

Monitoring visits to persons placed in police holding cells: Following unannounced monitoring visits, the Ombudsman took up a case with the Commissioner about some general questions concerning the monitoring of persons placed in police holding cells and the documentation in connection with placements. The case is pending.

MONITORING ACTIVITIES – CHILDREN

MONITORING VISITS, CHILDREN

No.	Date	Institution	DIGNITY/Danish Institute for Human Rights (IMR) participated	
1	14 January	'Skelbakken' in Karlslunde		
2	4 February	'Marjatta Skolehjemmet' in Tappernøje		
3	11 March	'Børnehusene Middelfart'		
4	9 April	'Pilely Gård' in Tølløse (**unannounced** visit)		
5	15 April	'Børneinstitutionen Posekær' in Aabenraa		
6	16 April	'Børnehuset Lille Kolstrup' in Aabenraa		
7	19 May	'Fogedvænget' in Hedensted	✓	
8	20 May	'Fenrishus' in Århus	✓	

1) At a number of this year's monitoring visits, the level of function of the children and young people made talks impossible.

	Talks with children and young people	Talks with parents and other relatives	Type of institution and target group
	0[1]	2	24-hour residential and respite institution for children and young people aged 0-23 years with permanently diminished psychiatric and/or physical functionality
	11	8	Accommodation facility for mentally handicapped children and young people aged 5-25 years In-house school
	5	3	24-hour residential institution for children with special needs aged 3-20 years with considerable and permanently diminished functionality
	12	0	Day care facility for boys aged 8-17 years with ADHD, among other things. Part of 'Behandlingsskolerne' (the Treatment Schools) In-house school
	0*	1	Residential institution for children and young people aged 0-18 years with a permanent psychiatric and/or physically diminished functionality
	2	4	Day nursery for disabled children aged 0-7 years Respite care institution for disabled children aged 0-18 years
	4	1	24-hour residential and respite care institution for young people aged 14-18 years with pervasive developmental disorders and rare disabilities
	0[1]	2	24-hour residential institution for children and young people with a considerable and permanently diminished physical and mental functionality and for children and young people in the terminal phase. Aged 0-18 years

Continued next page

MONITORING VISITS, CHILDREN

No.	Date	Institution	DIGNITY/ Danish Institute for Human Rights (IMR) participated	
9	8 September	'Specialbørnehjemmene': Fjordhuset' in Nørresundby	✓	
10	9 September	'Specialbørnehjemmene': 'Højbjerghus' in Støvring	✓	
11	6 and 7 October	'3Kløveren': 'Margueritten' in Snekkersten and 'Åbjerggård' in Frederikssund		
Total	**11** visits		DIGNITY participated in **4** visits, IMR did not participate	

	Talks with children and young people	Talks with parents and other relatives	Type of institution and target group
	5	2	24-hour residential institution for children and young people aged 0-18 years with multiple diminished functionalities
	0[1]	2	24-hour residential institution for children at the earliest stage of development and children in the terminal phase. Aged 0-18 years
	5	2	24-hour residential care and respite institution for children and young people aged 0-18 years (21 years) with permanently diminished physical and mental functionality
	44 talks	**27** talks	

EXAMPLES OF IMPORTANT REACTIONS IN 2015

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.

Thematic reports are published at www.ombudsmanden.dk

THEME: Children and young people who are day-time users of and residents at an institution due to considerable and permanently diminished physical and/or mental functionality

The Ombudsman's key conclusions

- In general, the institutions' staff were reflective in relation to the many practical and ethical dilemmas of daily life, and they were caring and development-oriented towards the children and young people.
- The institutions did not have written guidelines as to how the individual institution prevents sexual abuse and which procedure the institution follows when suspecting abuse. The Ombudsman generally recommends that institutions lay down such guidelines.
- The institutions were generally very engaged in and focused on communication with the children and young people and on the different ways in which the children and young people communicated.
- The visits shed light on a number of dilemmas, especially with regard to the balance between force and care.

Verbal recommendations to the institution's management

Medicine: A number of institutions were recommended to store medicine appropriately, for example in locked cupboards, so that the individual child's medicine was adequately separated from the other children's medicine.

Resuscitation and first aid: An institution with very sick children was recommended to consider laying down guidelines on basic resuscitation of children and regular refresher courses on first aid.

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Sexuality: Recommendation was given to the institution to reflect on the children's sexuality and on how the institution prevents abuse. See above under 'Themes'.

Uses of force: Recommendation was given to use forms in relation to children and young people (not adults) when the institution reports use of force. Recommendation was given to many institutions to inform parents and children placed in care about the rules stated in the Consolidated Act on Forcible Measures (in Danish only) including rules about possible channels of complaint. It was also recommended that a child or young person who has been exposed to a forcible measure is given the opportunity to state their version of the episode.

Discussions with key authorities

Forcible removal of children without a legal residence permit: The Ombudsman became aware that there is uncertainty as to whether the Social Services Act applies in cases where, for instance, it is necessary to forcibly remove a child who does not have a legal residence permit in Denmark. The Ombudsman took up the issue during a meeting with the Ministry of Social Affairs and the Interior and the Ministry of Immigration, Integration and Housing. An agreement was made that the Ministry of Social Affairs and the Interior informs the Ombudsman of the Ministry's deliberations about the scope of application of the Social Services Act in relation to foreign nationals.

Own-initiative cases and requests for statements

Action plans: Following monitoring visits, the Ombudsman took up seven cases on his own initiative about the lack of action plans. One case was concluded with criticism, while the other cases are pending.

Deportation of a child placed in care: In connection with a monitoring visit to 'Center Kongelunden', the Ombudsman was informed of a case where a child and his grandmother had been deported to Serbia after being denied asylum in Denmark. During the time prior to the deportation, the child had been in municipal care. The Ombudsman took up the case on his own initiative, and the case was concluded with criticism. The Ombudsman's Annual Report for 2015, Case No. 2015-8.

FOLKETINGETS
OMBUDSMAND

Thematic Report 2015

on placement in security cells

Doc. No. 15/00324-8/ME

What has the theme led to?

Placement in a security cell was a theme for the monitoring visits to Prison and Probation Service institutions which the Ombudsman carried out in 2015 in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

In general, it was the Ombudsman's assessment that a greater effort is required in order to ensure that the rules for placement in security cells are observed. The Ombudsman reviewed 35 reports on placements in security cells, and 4 of the reports contained a description of the course of events which aroused suspicion that the placement in a security cell or forced immobilisation was unjustified. In addition to this, the report also gave rise to suspicion in 6 cases that the inmate was mentally ill, and 27 of the reports did not state specific grounds why the inmate was forcibly restrained.

On the basis of his monitoring visits, the Ombudsman generally recommends that prisons and local prisons make sure that the conditions for placement in a security cell and possibly forced immobilisation are observed, and that documentation for this is provided. Moreover, the Ombudsman generally recommends that prisons and local prisons ensure that all reports on placement in security cells include documentation that a continuous assessment has been made on a regular basis regarding the need for continued placement in a security cell and possible immobilisation of the person placed in the cell.

The Ombudsman also generally recommends that prisons and local prisons make sure that a doctor is called in to check on the inmate in all cases of forced immobilisation, and that the doctor, if necessary, is informed about the duty to check on the inmate unless the doctor deems it clearly unnecessary.

Finally, the Ombudsman recommends that prisons and local prisons ensure that follow-up sessions are held systematically after the inmate has been placed in a security cell.

One particular visit has given cause for the Ombudsman to extract a specific placement in a security cell and to open an own initiative case asking for a statement which concentrates on, among other things, the role of the Department of the Prison and Probation Service as reviewing authority.

The Ombudsman has sent this report to the Department of the Prison and Probation Service so that the Prison and Probation Service can include it in their deliberations on this issue. The Ombudsman will discuss the follow-up of the general recommendations with the Prison and Probation Service. In addition to this, the Ombudsman will follow up on the recommendations during his monitoring visits.

Please read more about the Ombudsman's work on various themes in the appendix to this report.

Reasons for the choice of theme

Most of the closed prisons and some of the larger local prisons have a security cell. There is no furniture in a security cell apart from a bed on which an inmate can be physically restrained (forced immobilisation). It is possible to forcibly restrain the inmate on the bed by means of an abdominal belt, wrist straps, foot straps and gloves.

An inmate can be placed in a security cell, and possibly physically restrained, if it is deemed necessary in order to prevent the threat of violence or to overcome violent resistance or to prevent suicide or other self-harm.

It is a serious restriction for an inmate to be placed in a security cell and to possibly be physically restrained. This is emphasised in a judgment by Østre Landsret (the High Court of Eastern Denmark) of 4 June 2014 (Ugeskrift for Retsvæsen 2014.3045 Ø, the Danish weekly law reports). The judgment said that to the extent that placement in a security cell and immobilisation by means of wrist straps and foot straps together with an abdominal belt and possibly also gloves have been considered unjustified, then especially the immobilisation must be considered to lead to such intense physical and mental suffering that the restriction is subject to Article 3 of the European Convention of Human Rights. The rules laid down in this Article stipulate that no one shall be subjected to torture or to inhuman or degrading treatment or punishment.

The High Court found that the Prison and Probation Service had violated this Article of the European Convention of Human Rights in four cases by unjustified placement of an inmate with a custodial sentence in a security cell and forceful immobilisation of the inmate there to a plank bed, and in eight cases, where

immobilisation was justified, letting a basically reasonable placement in a security cell and immobilisation last longer than justified.

On these grounds, the Ombudsman wanted to investigate whether the Prison and Probation Service institutions comply with the rules for placing an inmate in a security cell and forceful immobilisation of an inmate, and whether placement in a security cell is maintained longer than justified.

Moreover, during his monitoring visits the Ombudsman is generally focusing on the use of force and other measures, disciplinary measures and informal actions.

The Ombudsman's monitoring visits are particularly aimed at society's most vulnerable citizens. The vulnerable citizens are, among other things, characterised by having very few resources, meaning that their rights can easily be put under pressure. This also applies for citizens who are detained, including inmates in the Prison and Probation Service institutions.

What did the Ombudsman do?

The Ombudsman investigated the theme in the following way:

- The Ombudsman visited 2 closed prisons and the closed sections of another prison with both closed and open sections and security cells. Furthermore, the Ombudsman also visited 4 local prisons with security cells. In total, the Ombudsman visited 7 institutions with security cells.
- Prior to the visit, the Ombudsman asked the prison or the local prison and the regional office of the Prison and Probation Service to forward a list of the total number of placements in security cells within the last three years. The authorities were also requested to state, together with the survey, the grounds on which the placement had taken place and the duration of the placement. In addition to this, the Ombudsman also asked to have the institution's latest 5 reports on placement in security cells and the individual supervision forms before the visit. In total, the Ombudsman received 35 reports with supervision forms from the 7 institutions.
- Prior to the visit, the Ombudsman's visiting team reviewed these reports and the supervision forms on the basis of a form that concentrated on compliance with essential procedural rules and of whether the measure could be considered justified both with regard to the placement in a

security cell as such and to the use of forced immobilisation. Please see the form in the appendix to this report.
- The discussions which the Ombudsman's visiting team had with the management, staff and inmates at the institution focused on the use of security cells, among other things.

The monitoring visits were carried out as part of the Ombudsman's general monitoring activities pursuant to section 18 of the Ombudsman Act and as part of the Ombudsman's task of preventing exposure to, for instance, inhuman or degrading treatment of persons who are or may be deprived of their liberty; cf. the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The Ombudsman's work to prevent degrading treatment, etc. pursuant to the Protocol is carried out in cooperation with the Danish Institute for Human Rights and with DIGNITY – Danish Institute Against Torture. DIGNITY and the Institute for Human Rights contribute to the cooperation with special medical and human rights expertise meaning, among other things, that staff with this expertise participate in the planning and execution of and follow-up on monitoring visits on behalf of the two institutes.

What did the Ombudsman find?

On the basis of the completed monitoring visits and review of the reports on placement in security cells and the individual supervision forms, the Ombudsman noted the following, among other things:

- In 34 out of 35 cases the inmate was not only placed in a security cell but was also forcibly immobilised to the bed with belts and foot straps. In 32 cases wrist straps were also used in connection with the forced immobilisation.
- 4 of the reports contained a description of the precedent course of events which raised the suspicion that the placement in a security cell or the forced immobilisation was unjustified.
- In 6 cases, the description in the report raised the suspicion that the inmate was mentally ill.
- 27 of the reports on placement in security cells did not state specific grounds for forcible immobilisation of the inmate. In 10 cases, however, the grounds

were indirectly stated in the description of the course of events which led to the placement in a security cell and the forced immobilisation.

- None of the reports on placement in security cells where other measures of immobilisation than belt were used (i.e. wrist straps, foot straps and gloves) included specific grounds for the use of these measures of immobilisation.
- 16 reports on placement in security cells did not clearly document whether it was justified to maintain the placement in a security cell until the time of the last supervision.
- In all 34 cases where the inmate had been forcibly immobilised, the inmate was permanently supervised.
- All 35 reports with supervision forms contain information about the staff's supervision of the inmate.
- 23 of the 34 supervision forms concerning cases where the inmate was forcibly immobilised include notes about the staff's supervision of the inmate every 15 minutes during the entire period of forced immobilisation.
- 30 supervision forms do not include information about a continuous need for upholding placement in the security cell.
- 9 reports on placement in security cells stated that a forcibly immobilised inmate had not received any medical attention.
- During the monitoring visits, the Ombudsman's visiting staff were informed that the Ombudsman's choice of selecting placement in a security cell as a theme for monitoring visits had led to a greater focus in the Prison and Probation Service institutions to ensure that the rules for placement in a security cell were observed and that the documentation of the individual placement in a security cell became more detailed.

Conditions for placement in security cell

An inmate in a prison or a local prison can be placed in a security cell pursuant to the Sentence Enforcement Act.

Placement in a security cell must only be used if it is deemed necessary in order to prevent the threat of violence or to prevent suicide or other self-harm. However, an inmate should not be placed in a security cell if the purpose, the infringement and the discomfort, which the measure is considered to cause, result in a disproportionate measure. Placement in a security cell must be undertaken as gently as the circumstances permit.

The inmate is only to be placed in a security cell as long as deemed necessary. The inmate must be taken out of the security cell when less coercive measures than placement in a security cell in order to prevent threatening violence or overcoming heavy resistance or to prevent suicide or other self-harm are sufficient. Therefore, it must be frequently assessed whether the placement of the inmate in a security cell remains necessary.

The European prison rules, adopted by the Committee of Ministers of the Council of Europe in 2006, stipulate that mentally ill persons, whose mental state of health are irreconcilable with imprisonment, should be imprisoned in an institution specifically aimed at this purpose.

6 of the 35 security cell reports, reviewed by the Ombudsman, contained a description of the preceding course of events which gave rise to the suspicion that the inmate was mentally ill.

4 reports contained a description of the preceding course of events which gave rise to suspicion that the placement in a security cell or the forced immobilisation was unjustified.

19 reports contained a description of the supervision which indicated that it was justified to uphold the placement in a security cell until the time when the last supervision was carried out. 16 reports did not indicate – or did not clearly indicate – that this was justified.

30 security cell reports with supervision forms, received by the Ombudsman, do not contain information as to whether there was still a need for maintaining the placement in a security cell.

The visiting team informed an institution that one of the five security cell reports which the institution had sent to the Ombudsman contained a continuous assessment of the need for placement in a security cell and immobilisation while this information was not included in the four other reports. The visiting team recommended that the management take steps to ensure that all future security cell reports include documentation of an ongoing assessment of the placement and the immobilisation. Representatives from the prison and probation service sector supported this recommendation and the management agreed to the recommendation. The management stated that they would work on finding a

suitable procedure to ensure the necessary documentation in future security cell reports.

The visiting teams made similar recommendations to other institutions, apart from institutions where the management during the meeting informed the visiting team that they had already a more stringent focus on compliance with the terms of placement in a security cell and possible immobilisation together with focus on documentation in the security cell reports regarding a continuous assessment of the placement and the immobilisation.

At one institution the visiting team recommended that the staff avoided putting a pillow case over an inmate's mouth in order to protect themselves from spit and, for example, considered using a plastic screen instead.

Conditions for the use of forced immobilisation

When an inmate is placed in a security cell, there is – as mentioned – a possibility of forcibly strapping the inmate to a bed in the cell by using a belt and possibly also hand straps and foot straps as well as gloves.

The conditions for forcibly immobilising the inmate are the same as those which apply to the placement in a security cell itself. This means that the inmate must only be immobilised if it is deemed necessary in order to prevent the threat of violence or to defeat violent resistance or to prevent suicide or other self-harm. An inmate must not be immobilised if the purpose of the measure and the violation and the discomfort which the measure is presumed to cause would be considered a disproportionate measure. The immobilisation must be undertaken as gently as circumstances permit.

The fact that the conditions for immobilising an inmate correspond to the conditions for placing the inmate in a security cell does not mean that when it is deemed necessary to place an inmate in a security cell, the inmate must be immobilised. When a prison or a local prison decide to place an inmate in a security cell, an individual decision has to be made whether it is necessary to immobilise the inmate too and, if so, which kind of fixation measures (belt, hand straps and foot straps together with gloves) are considered necessary.

The inmate must only be immobilised as long as deemed necessary. Consequently, the prison or the local prison must release the inmate from the immobilisation when it is considered sufficient to make use of less coercive measures than immobilisation in order to prevent violent resistance or to prevent suicide or other self-harm. Therefore, the prison or the local prison must on a regular basis assess whether it remains necessary to immobilise the inmate.

A separate assessment has to be made whether the immobilisation is necessary even if the assessment is that it remains necessary to place the inmate in a security cell. If it is still necessary to immobilise the inmate, a separate assessment has to be taken whether other fixation measures than belt are necessary. An immobilisation must only as an exception last longer than 24 hours.

The review of the reports on placement in security cells indicated, among other things, that in most cases where placement in a security cell had been undertaken, the inmate was strapped to a bed in the security cell by means of a belt and foot straps. Only one out of 35 reports showed that the inmate was placed in a security cell without any kind of immobilisation. 32 reports out of a total of 34 reports on immobilisation stated that the inmate was not only immobilised by means of belt and foot straps but also by means of hand straps. In comparison, gloves were only used as an immobilisation measure in 3 cases.

In 7 cases the security cell report includes specific grounds for immobilisation of the inmate, whereas 27 reports do not include such grounds. However, in 10 cases the grounds appeared indirectly from the description of the course of events which led to the placement in a security cell and the immobilisation. None of the reports received by the Ombudsman state any information that the staff made a separate decision whether it was considered necessary to not only make use of a belt but to use hand straps and foot straps too, and possibly gloves in order to immobilise the inmate.

There were no cases of inmates having been immobilised by means of a belt or foot straps where the use of these fixation measures was brought to an end prior to termination of the placement in a security cell. There was, however, one case where the use of hand straps ceased while the inmate was still immobilised, and there was an additional case where the use of gloves ceased while the inmate was still immobilised.

In one institution the management said that an individual assessment was made on whether the conditions for placement in a security cell and immobilisation were met but usually immobilisation was used in all cases of placement in a security cell. On the basis of this information, the visiting team emphasised that a specific and individual assessment has to be made as to whether it is necessary to immobilise the inmate.

In one of the institutions visited by the Ombudsman, a clock hung on the wall and a fire alarm was placed in the ceiling. It was possible to put a piece of cloth around the clock or the fire alarm which could then be used to hang oneself, meaning that the security cell could not be used for placement of inmates in order to prevent suicide or other self-harm unless the inmate was immobilised on the bed. The visiting team recommended that the security cell was designed so that in terms of safety it was justifiable to place inmates in the cell in order to prevent suicide or other self-harm without using immobilisation.

Supervision

The staff must regularly check on an inmate placed in a security cell.

If an inmate is immobilised, the inmate must have a permanent guard. As permanent guard can be used either a prison officer or another qualified staff member who has no other task than taking care of the immobilised inmate. It must be ensured to the extent possible that an experienced, permanent staff member is used and that the staff member in question did not participate in the current immobilisation. The institution should consider whether it is advisable to use a staff member with a good knowledge of the inmate which will often, but not always, be the case.

The review of the security cell reports and the supervision forms indicated that in all the 34 cases concerning immobilisation of an inmate, the inmate was permanently supervised.

An institution informed the Ombudsman’s visiting team that the work was typically carried out according to a ”rolling staff rota” with change of guard every half to 1 hour because permanent watch takes a toll on the staff. The visiting team recommended that the management reconsider this procedure and consider an arrangement where regard for the inmate is taken into account to a higher

degree, such as an arrangement where the inmate does not have to relate to a new permanent guard every half hour and to make sure that the possibility of following a possible development is increased.

If an inmate is placed in a security cell without immobilisation, a doctor must be sent for to check on the inmate if there is suspicion of illness, including bodily injury of the inmate, or if the inmate himself requests medical attention. When an inmate is immobilised, the institution must immediately request a doctor to carry out medical attention on the inmate. The doctor must check on the inmate in question unless the doctor assesses that such medical attention is unnecessary. The doctor's task is to assess the inmate's state of health.

9 reports on immobilisation include information that a doctor did not check on the inmate.

In one of these cases, the inmate did not wish medical attention from a doctor and received medical attention from a nurse instead.

Two reports have reference to a case where the inmate received medical attention from a nurse who assessed that the inmate should receive medical treatment at the hospital casualty ward due to a suspected fracture/concussion of the brain. However, because the casualty ward was busy the inmate was sent back to the institution without receiving any medical attention, and he was immobilised in the security cell again. After this placement in a security cell, which lasted 1 hour and 43 minutes, the police took the inmate to the hospital casualty ward so that he could receive medical attention.

In the other cases, where a doctor had been sent for, the doctor considered that medical treatment was unnecessary.

At a number of institutions, the management said that it was a frequent problem to persuade the doctor on call to come and check on an inmate in a security cell. One institution management said that the institution was currently working on entering into continuous cooperation agreements in this regard. The visiting teams recommended to these institutions that they should, if necessary, inform the doctor that pursuant to the Sentence Enforcement Act a doctor is under an obligation to check on the inmate unless the doctor assesses it to be manifestly unnecessary.

The visiting team recommended to another institution that it would be advisable if the doctor's remarks in the security cell reports be more detailed, including an assessment in the reports of the inmate's health together with the appropriateness of the placement in a security cell and a possible immobilisation.

The visiting team, which, among others, included a doctor from DIGNITY, expressed to another institution that the doctors' records varied a lot, from a description of the inmate's appearance to assessments of possible causes for the agitated state. In general, it seemed that there was a need for a medical guide for – especially external – doctors who undertake supervision of inmates as to what factors a doctor must assess.

Recommendation was given to a number of institutions that they make sure that the inmate's medical records include a copy of the doctor's records regarding the placement in a security cell.

Reporting

The prison or the local prison must soonest possible draw up a report on the use of security cells, including immobilisation. The report must include information about the grounds for using a security cell.

In addition to this, the report must also include information about date and time when the use of the security cell ended as well as information on whether the inmate has been informed about the possibility of complaining to the Department of the Prison and Probation Service, and when the deadline for lodging a complaint expires. Furthermore, the report must also include information about the institution's considerations regarding medical attention.

When the staff supervise an inmate placed in a security cell, a note must be made in the supervision form, even if there are no changes in the inmate's condition. During the inmate's immobilisation in a security cell, a note must be made at least every 15 minutes about the supervision. The supervision form must include information about date and time of the supervision as well as information about the inmate's condition, including possible remarks concerning the need to maintain the placement in the security cell.

All 35 reports with supervision forms reviewed by the Ombudsman included notes about the staff's supervision of the inmate. 30 supervision forms stated date and time of all supervisions. 22 of the 34 supervision forms concerning cases where the inmate was immobilised include notes about the supervision at least every 15 minutes during the entire period of immobilisation.

33 supervision forms include notes with information about the inmate's condition during the placement in a security cell, whereas only 5 supervision forms include information as to whether there was a continuous need for maintaining the placement in the security cell.

At a number of the visited institutions, the visiting team recommended to the management that they increase their focus on ensuring that the reports include complete documentation of the course of events together with grounds for the placement in a security cell, the use of immobilisation, the use of each measure of fixation together with the continuance of the placement and immobilisation. In general, the institution managements agreed to these recommendations, and some of the institutions had implemented initiatives aimed at improving the documentation process. Recommendation was also given to a number of institutions to increase accuracy with regard to the frequency of the staff's supervision and registration of the time of supervision.

If the prison or the local prison decides to maintain the placement in a security cell for more than three days or to continue an immobilisation for more than 24 hours, the institution must immediately report this to the Department of the Prison and Probation Service. If the use of security measures, including security cell, lasts more than 24 hours, the doctor must also be kept informed on a daily basis so that the doctor in question on the basis of his knowledge of the inmate, among other things, can assess whether medical attention is necessary.

In one case, the immobilisation lasted 4 days, 7 hours and 2 minutes. It appears from the security cell report that the inmate received medical attention from a doctor on the first and the fourth day. Apart from this, there is no information whether a doctor was informed daily about the inmate's continuous placement in a security cell. In connection with the case mentioned below, the Ombudsman has received a copy of the case files from the Department of the Prison and Probation Service. It appears from the case files that the Department of the Prison and Probation Service was informed of the case by the institution approximately 13 hours later together with information that at present it seemed

that the immobilisation would probably last the entire weekend or at least more than 24 hours. This report, which was sent on a Friday, was followed up by new information to the Department of the Prison and Probation Service on the fourth day of the immobilisation. The Department of the Prison and Probation Service took note of the information from the institution.

The Ombudsman has opened a case on his own initiative about this security cell placement. Among other things, the Ombudsman has asked the Department of the Prison and Probation Service to give an account of the examination undertaken by the Department in the case, including whether the Department had assessed the case with a view to the judgment of the Østre Landsret (the High Court of Eastern Denmark) of 4 June 2014 which is mentioned on page 3 in this report. The case is pending.

Guidance of complaint and follow-up sessions

The inmate can lodge a complaint with the Department of the Prison and Probation Service about a decision to place the inmate in a security cell, including a decision to use forcible restraint. The inmate must lodge a complaint within two months, but in special cases the Department can disregard this deadline.

If an inmate is placed in a security cell, the prison or the local prison must give guidance to the inmate about the possibility of lodging a complaint with the Department of the Prison and Probation Service and information about the deadline of two months for lodging a complaint. It must appear from the security cell report that the inmate has received this guidance.

The review of the security cell reports showed that 21 of the 35 reports included information that the inmate had been given guidance about the possibility of lodging a complaint with the Department of the Prison and Probation Service and the deadline for lodging a complaint. It appears from 12 security cell reports that the inmate had been given guidance on lodging a complaint but it does not say whether the inmate was also given guidance on the deadline for lodging a complaint. Two reports did not state any information whether the inmate had been informed about the possibility of complaining or the deadline for lodging a complaint.

As an example, one of the institutions to which the Ombudsman paid a monitoring visit stated in all five security cell reports that the inmates had been given guidance on lodging a complaint but details of the contents of the guidance such as the deadline for complaining did not appear from the reports. Based on this, the visiting team recommended drawing up standardised texts to be used in these reports in order to provide more accurate documentation of the guidance given in connection with placement in security cells. The representatives of the regional office agreed to this recommendation which was also accepted by the management.

As soon as the inmate is taken out of the security cell, the prison or the local prison must offer the inmate a talk, a so-called follow-up session, with a permanent staff member. The follow-up session is aimed at giving the inmate the possibility of talking about his or her experience of the security cell placement.

Two of the institutions to which the Ombudsman paid a monitoring visit said that the inmate who had been placed in a security cell had a subsequent follow-up session with a nurse, and a third institution informed the visiting team that the procedure for follow-up sessions was probably not very systematic but that a session between the inmate and the staff normally took place after the inmate had been taken out of the security cell. Other institutions did not arrange follow-up sessions but some of them, however, said that after the placement there were often grounds for questioning during which the inmate was also given the opportunity of expressing his or her opinion on the course of events.

The visiting team recommended to the institutions which did not undertake systematic follow-up sessions to introduce such sessions.

Copenhagen, 12 May 2016

Jørgen Steen Sørensen

FOLKETINGETS OMBUDSMAND

Thematic report 2015
on individual support programmes
(’enkeltmandsprojekter’)

Doc. No. 15/01652/
EDS/SOS

What has the theme led to?

The treatment of persons in individual support programmes (so-called 'enkeltmandsprojekter' in Danish) was selected as a theme for the monitoring visits which the Ombudsman carried out in the adult social care sector in 2015 in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

Individual support programme is an overall term for the special measures which the Act on Social Services provides for citizens with a behaviour so problematic that they cannot be accommodated in the normal social interaction at specialised residential facilities for people with, for instance, mental disorders or physical disabilities.

It was the Ombudsman's overall assessment that the staff at the institutions were generally reflective in relation to the many practical and ethical dilemmas of everyday life, and that they were development-oriented towards these particularly fragile citizens. The physical conditions for these citizens were good, and the (30) relatives and guardians with whom the Ombudsman and his team spoke during the visits expressed, with a few exceptions, great satisfaction with the conditions and with the staff's efforts.

However, the monitoring visits to the 14 institutions included in the Ombudsman's survey also showed that the staff encounter various dilemmas in their efforts to provide the best possible treatment for the citizens. These typically arise because the legislation does not allow the staff to use force to carry out measures which are necessary for the citizen or are in the best interest of the citizen, such as for instance a necessary health examination.

Following visits to two institutions, the monitoring visits also led to the Ombudsman opening own initiative cases on whether the provisions for the use of force in the Act on Social Services has been observed in specific instances.

And finally, the monitoring visits showed that in many instances of the use of force the responsible municipalities do not provide notification and guidance on channels of complaint, and that the responsible municipalities do not have a uniform practice on responding to the institutions' reports on the use of force.

Similar dilemmas are found in the children and young people social care sector.

The thematic report will be submitted to the Ministry of Social Affairs and the Interior and to the Ministry of Health so that the ministries can include it in their deliberations concerning the problematic issues. At a meeting between the Ombudsman and the Ministry of Health in January 2016, there was a preliminary discussion of the report's problematic issues regarding healthcare.

The thematic report has also been sent to the National Board of Social Services, the social supervision authorities and those institutions which the Ombudsman visited as part of the theme.

Reasons for the choice of theme

The purpose of the Ombudsman's monitoring of the social care sector is particularly to help ensure that society's most vulnerable citizens are treated with dignity and respect and overall in accordance with their rights.

At the time when individual support programmes were selected as one of the themes for the Ombudsman's monitoring visits in 2015, there had been media coverage of several cases in which citizens in individual support programmes had been victims of neglect of care and, in some instances, of unlawful use of force.

In Denmark, there are five social supervision authorities (one in each Region) which supervise social institutions. According to information which the Ombudsman received from the social supervision authorities, there were no systematic examinations of conditions for citizens in individual support programmes, and the supervision by these authorities of institutions in the social care sector is not directed specifically at these citizens but at the institutions in general.

On this basis, the Ombudsman decided in 2014 to assess conditions for these persons in his 2015 monitoring visits in the social care sector.

What did the Ombudsman do?

How was the investigation organised?

All information about social institutions can be found on the internet, through the Social Services Gateway. However, after the decision had been made to look into individual support programmes, it turned out to be difficult to identify such 'individual support programmes' ('enkeltmandsprojekter' in Danish) through the Social Services

Gateway or by searching on the internet, including the homepages of the individual municipalities. In addition, 'individual support programme' is not a uniform concept but will also be listed under such names as 'special measures', 'solo projects' or 'summer house projects'. The concept is not used in the Social Services Act either, and it has over time and in various contexts been defined in slightly different ways.

For use in his investigation of the sector, the Ombudsman chose the definition in the 2010 report "Tilbud til voksne med problemskabende adfærd" (Programmes for adults with behavioural problems (only available in Danish)) by the 'Vidensteam' (a group of experts under the National Board of Social Services), in combination with the definition used in the same Board's 2014 report "Særforanstaltninger – anbefalinger til god praksis for organisering, samarbejde og borgerinddragelse" (Special measures – recommendations for good practice in organisation, cooperation and user involvement (only available in Danish)). The first report can be found on the homepage of the 'Socialpædagogernes Vidensbank' (socio-educational workers' knowledge bank), while the latter can be found on the homepage of the National Board of Social Services.

Because of the difficulties in identifying persons in individual support programmes and their residential facilities, the Ombudsman asked the five largest municipalities and five randomly picked municipalities, evenly distributed geographically, to state which persons the municipalities had decided to give special assistance in the form of individual support programmes. The persons should meet the following conditions:

- The person must be staying at a residential facility or be in a comprehensive programme for which the overall rate for 24 hours is at least DKK 5,000 (all inclusive).
- In addition, the person must be an adult (+18 years) with a permanent functional impairment. The functional impairment must be due to mental retardation, late onset brain damage and/or autism spectrum disorders or other fundamental development disorders.
- The person must also exhibit problematic behaviour which requires a staffing level of at least 1:1.

On the basis of the information received from the 10 municipalities, the Ombudsman selected 14 institutions to visit. The visited institutions appear in appendix 1.

The institutions were picked so that they covered all parts of Denmark and all three types of ownership, meaning private (3), municipal (9) or regional (2). The visits to the

14 institutions included a total of 79 persons who were covered by the above-mentioned definition.

What was examined during the visits?

During the visits, the Ombudsman focused especially on the following conditions:

- Use of force, including number and procedures
- Other interventions vis-à-vis the users
- Physical conditions for users, including their developmental activities
- Relationship between users and staff, including the issue of violence and intimidation (both users towards staff, users towards other users, and staff towards users)
- Relationship between users and their relatives/guardians, including the way in which the institution endeavours to maintain/improve the relationship
- Healthcare services for the users, including the institution's medicines management

How were conditions examined?

Prior to each visit, the Ombudsman asked the institution for information about a number of factors, partly about the institution's overall circumstances and partly about the users included in the visit.

In addition, the institution was asked for a brief statement (a total of no more than three pages) on the following issues: 1) how the institution prevented that the users ended up in inhuman and degrading situations, 2) which significant, problematic incidents the institution had experienced within the last 12 months, 3) what professional (not financial) main challenges the institution had faced in 2015, 4) how the users' access to medical services was organised, and 5) the institution's use of substitute staff (when did the institution use substitute staff, to what extent, and what were the substitute staff's qualifications).

Lastly, the municipalities responsible for the users in individual support programmes (the acting authority) at the relevant institution was asked to forward the three most recent reports from the person-centred supervision which the municipality had carried out regarding the user.

The responsible social supervision authorities were invited to participate in each monitoring visit. In this context, the Ombudsman asked the social supervision

authorities to state whether the authorities had found cause for notifying the placing municipalities in connection with the authorities' supervision of the institutions. The social supervision authorities participated in the large majority of the Ombudsman's monitoring visits.

During the visits, the Ombudsman's monitoring team had talks with the institution's management, staff (including health care personnel), relatives and guardians and with the residents. The monitoring teams had talks with 30 relatives, of whom 13 were guardians, and with 15 residents. It was not possible to have a conversation with most of the 79 residents, either because they did not have any language or because they had difficulties to such an extent that a conversation with strangers would affect their mental state negatively.

The monitoring visits were carried out as part of the Ombudsman's general monitoring activities pursuant to section 18 of the Ombudsman Act and as part of the Ombudsman's task of preventing exposure to for instance inhuman or degrading treatment of persons who are or may be deprived of their liberty, cf. the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The Ombudsman's work to prevent degrading treatment, etc. pursuant to the Protocol is carried out in cooperation with the Danish Institute for Human Rights and with DIGNITY – Danish Institute Against Torture. DIGNITY and the Institute for Human Rights contribute to the cooperation with special medical and human rights expertise, meaning among other things that staff with this expertise participates in the planning and execution of and follow-up on monitoring visits on behalf of the two institutes.

What did the Ombudsman find?

As mentioned above, it was the Ombudsman's overall assessment that the institutions' staff were generally reflective in the many practical and ethical dilemmas of everyday life, and that they were caring and development-oriented towards these particularly fragile citizens. The physical conditions for these citizens were good, and the (30) relatives and guardians with whom the Ombudsman and his team spoke during the visits expressed, with a few exceptions, great satisfaction with the conditions and with the staff's efforts.

Dilemmas

More than half of the visited institutions stated that there were residents for whom it was very anxiety-triggering to have to go to the dentist, doctor's or to the hospital to have a filling put in or to have their teeth cleaned, to have blood samples taken or to undergo other examinations and operations. These residents were often without any language and had a developmental age of between 2 and 4 years of age. They were consequently unable to understand the necessity of consenting to the treatment or examination. Procuring consent from guardian or relatives was not a problem in this context, according to information from the institutions and the relatives. The problem was that the resident physically resisted in connection with necessary examinations or treatment.

The Ombudsman was informed of several incidents when it had finally been necessary for the staff to use force to restrain the resident so that the required treatment, blood sampling or examination could be carried out. Some institutions had chosen to report such uses of force as non-statutory use of force to both the placement municipality and the relevant social supervision authority.

A couple of institutions stated during the Ombudsman's monitoring visit that they had informed the Ministry of Social Affairs a few years ago of the non-statutory uses of force with a view to having the Ministry look into the issue.

In most situations where force had been used, the resident had been restrained for a short time, until the sedation worked or the blood sample had been taken. However, the Ombudsman's monitoring team was also informed of a few incidents when the use of force had been more extensive. In one case an institution had an incident when a younger resident during a nature walk had had a serious fall. The fall had resulted in one of the resident's legs being broken in several places. None the less, the resident had attempted to run away on his broken leg, and the staff member had had to restrain the resident on the ground for quite some time before the paramedics came to the rescue.

In the hospital, the resident had resisted treatment and kicked out with his broken leg which was to be operated on and put in a cast. In order to ensure that the resident received the required treatment, several members of the institution's staff had to restrain him. The responsible authority had subsequently carried out a very thorough analysis of the incident with a view to the institution learning from the experience.

The media has mentioned some instances where a resident had resisted medical examination and where those medical examinations had not been carried out using coercion. The lack of medical examination had meant that the resident had not received the necessary treatment and had consequently died.

Both management and staff at the institutions visited by the Ombudsman knew that the use of force in such situations had no authority according to the Social Services Act or the Health Act.

Management and staff encounter the dilemma in situations where it is not possible, despite pedagogic efforts, to achieve a voluntary acceptance of a necessary treatment or examination but where the treatment or examination is required in order to ensure that the resident's medical condition does not deteriorate. The Social Services Act does not give the authority to use force in these situations but in the assessment of the institution, omitting examination or treatment does constitute neglect of care towards the resident.

Section 126 of the Social Services Act lists several conditions to be met in order for emergency use of force to be considered lawful. Section 126 stipulates as follows:

> **"Section 126.** The municipal council may decide to use physical force in restraining a person or leading a person to another room where
> 1) there is an imminent risk that the person may cause substantial injury to himself/herself or other persons, and
> 2) it is absolutely necessary in the given situation."

In many health treatment situations, such as teeth brushing, orthodontic treatment or measuring blood glucose level for the adjustment of diabetes medication, there is in the institutions' opinion no basis for the use of physical force according to section 126 of the Social Services Act. On the other hand, failure to carry out such health treatments can – especially over time – constitute a neglect of care.

Section 19 of the Health Act allows non-consensual medical treatment in certain strictly limited situations. Section 19 stipulates as follows (unofficial translation):

> **"Section 19.** If a patient, being temporarily or permanently unable to give informed consent or being under the age of 15, is in a situation where immediate treatment is necessary for the patient's survival or for a more long-term improvement of the patient's chance of survival or for a significantly better

> outcome of the treatment, a healthcare professional can start or continue a treatment without the consent of the patient or of the custodial parent, next of kin, or guardian."

Forced treatment is carried out on the grounds of *jus necessitates* in order to prevent grave injuries to the patient, cf. i.a. Mette Hartlev et al., Sundhed og Jura (2013), page 148 f. (only in Danish) and item 134 of Practice Note to the Social Services Act on the Use of Force and other Infringements of the Right of Self-determination towards Adults, including Pedagogic Principles (Practice Note No. 8 of 15 February 2011, only in Danish).

There are no regulations in the Danish Health Act on the use of force to avoid neglect of care.

The resident's encounters with other people outside the institution

The Ombudsman was informed several times that during excursions outside the institution, persons in individual support programmes may run into situations with outside persons where it may be necessary, due to the residents' behaviour, to pull the residents away to avoid physical confrontations. However, these situations may not present an obvious risk of significant bodily injury and there is therefore no authority to use force towards the resident pursuant to section 126 of the Social Services Act.

The Ombudsman's monitoring team was also informed of incidents where residents had subjected themselves to degrading situations by undressing in public. Nor in these situations do the regulations in the Social Services Act allow the use of force to lead the resident away.

And lastly, situations where the resident suddenly wants to run away were mentioned. Such situations may quickly escalate to present real danger to the residents who may wander into high-traffic areas, as these residents are far from being safe in traffic.

According to the Social Services Act, staff are only allowed to use pedagogic measures in such situations. However, according to information received by the monitoring team, there were several times when the pedagogic efforts were not sufficient and that persons in individual support programmes had been exposed to verbal or physical reactions which had had a great negative impact on them.

Several institutions therefore expressed a wish for more extensive authority to intervene concerning this group of citizens in escalating situations. It was stressed that the wish was solely based on a regard for the best protection of and care for these citizens.

In some of the conversations with relatives/guardians, the relatives/guardians expressed the spontaneous wish that the institutions would, far more than was actually the case, use force in order to avoid that the citizen was exposed to degrading or extremely unpleasant situations.

The resident's encounters with other residents at the institution

In institutions with more than one resident in an individual support programme, the institution will often attempt to create a social contact between these residents or with other groups at the institution who are also mentally impaired but who are not in an individual support programme. It sometimes happens in such social situations – often quite unpredictably – that an individual support programme resident may start to scream or destroy furniture and equipment or hit out at the other residents. Such behaviour is very anxiety-provoking for the other residents present.

The dilemma for the staff is that the care they wish to provide for the residents cannot be put into practice by leading the resident with the anxiety-provoking behaviour out of the room by use of force, such as taking the resident by the arm. As mentioned above, the Social Services Act's regulations on the use of force presuppose that "there is an imminent risk that the person may cause substantial injury to himself/herself or other persons" and that "it is absolutely necessary in the given situation". It may therefore be some considerable time before the institution staff, using only pedagogic means, manage to get the resident with the anxiety-provoking behaviour or the other residents out of the room. According to the institutions, such incidents trigger anxiety in the residents which may take days or longer to wear off.

On this background, some institutions and certain relatives/guardians expressed the view that it would benefit both the anxiety-provoking resident and the other residents if the use of force was permitted in a limited form in these situations.

The resident and transport

Several institutions used an H-harness with a magnetic catch when transporting the resident in the institution's bus. The resident would be able to open ordinary safety

belts, and this could cause serious problems with regard to traffic safety because the resident would grab or hit the driver. The dilemma arises when the resident has been strapped in the H-harness willingly but subsequently wants to be released from it. The resident cannot do so on his or her own when an H-harness is used. Thus, the resident is restrained by the harness against his or her will.

The regulations of the Social Services Act do not allow such a restraint. Nor would the consent of a guardian mean that it would be lawful to restrain the resident against his or her will. This follows from both the above-mentioned guidelines and of the legislative history of the Guardianship Act.

At a couple of the institutions, the Ombudsman's monitoring team was informed that a municipality with the acting authority for a resident had given permission to use the H-harness. On these occasions the monitoring team stated that in the Ombudsman's opinion, such permissions could not be given under the provisions of the Social Services Act.

At those institutions where the Ombudsman's monitoring team was informed of the use of an H-harness with a magnetic catch, the resident's guardian/relatives were informed thereof and concurred therein, according to the institutions.

The monitoring team's talks with guardians/relatives on the use of the H-harness indicated that these did not consider the use of the H-harness to be a problem and that they could not think of any other solution.

The resident and personal safety equipment

A few of the residents included in the investigation suffered from epilepsy or had such poor motor function that they were prone to falling with resulting fall injuries. In one instance, this had resulted in a massive concussion, and in another, a skull fracture.

The institutions use, among other things, safety helmets for the residents in order to avoid such injuries. However, in certain instances the residents do not wish to wear the helmet. The provisions of the Social Services Act do not allow using force to make the resident wear the helmet. The institutions with residents who needed a safety helmet informed the Ombudsman's monitoring team that the resident's wish not to wear a helmet was always respected.

Naturally, the institutions tried to compensate for the risk of injury to the resident by staff always being very close to the resident in such situations in order to be able to catch the resident in time. However, it did worry the staff greatly that they were not able to fully safeguard the resident from the serious accidents which did happen from time to time.

Relatives of residents needing a safety helmet expressed to the monitoring team their frustration that the legislation was so designed as to make it impossible to force a resident to wear a helmet in situations involving serious risks.

Own-initiative cases

There were factors at two of the institutions which gave the Ombudsman cause to raise concrete own-initiative cases.

One of the visited institutions said that when transporting a resident in the institution's vehicle, they used an H-harness with a magnetic catch which the resident could not get out of without help. Furthermore, the resident was fitted with a walking harness – by all accounts voluntarily – when the staff went for a walk with the resident.

The institution believed that the municipality acting for the resident, which also owned the institution, had given permission to use the H-harness, and that the use of the walking harness could be based on regards for the staff's occupational health.

The Ombudsman asked the responsible municipality for a more detailed account of any decisions made by the municipality regarding the use of the H-harness and the walking harness, including the legal grounds for the decisions.

The Ombudsman has not concluded his processing of this case.

At another of the visited institutions, a special alarm/door opener with delayed action was used in a resident's room. This special door opener was meant to prevent the resident from getting out of the room without the knowledge and active follow-up by the staff, thus getting herself into a situation where she could be a risk to herself or to others.

It appeared from the material which the institution had sent the Ombudsman that the municipality acting for the resident seemed to have given the permission in 2013 and that the permission had been extended indefinitely in connection with the

municipality's preparation of the 2014 action plan for the resident. The precise statutory authority did not appear from the 2013 decision, and the action plan did not state on which grounds the municipality had decided that the measure should be extended indefinitely.

On that basis, the Ombudsman asked the municipality acting for the resident to give a more detailed account of the grounds for the decision and for extending it indefinitely.

The Ombudsman has concluded this case. He concurred with the assessment in the municipality's consultation response that there was no statutory authority to give an indefinite permission to the alarm/door opener in question. The Ombudsman therefore found it to be regrettable that there had for a period of time been such measures in place for the resident without the necessary authority.

Reports on forcible measures, notification and guidance on complaint

During the visits, the Ombudsman's monitoring team in particular discussed emergency uses of physical force pursuant to section 126 of the Social Services Act with the accommodation facilities. The following concerns such uses of force.

Reporting of forcible measures

Section 136 of the Social Services Act states the rules for the reporting of forcible measures. The provision says as follows:

> **"Section 136(1).** Admission to special accommodation facilities under section 129 and any forcible measures taken, including in connection with measures under sections 125-128, shall be registered and reported by the facility to the municipal council responsible for the resident's placement at the facility, cf. section 9 and 9b of the Act on Legal Protection and Administration in Social Matters, and to the municipal council responsible for supervising the operation of the facility, cf. section 148a of this Act or section 2 of the Act on Social Supervision. Is the resident concerned in the report placed at a municipal or regional facility, that facility shall in addition inform the municipal or regional operator of the forcible measure.
> *(2)* The municipal council shall draw up action plans in accordance with section 141 for persons in relation to whom the measures referred to in subsection (1) hereof are implemented."

This provision is further clarified in section 9 of the Executive Order on forcible measures and other restrictions in the right of self-determination of adults and on special safety measures for adults and the duty to accept persons in the accommodation facilities covered by the Social Services Act (Executive Order No. 392 of 23 April 2014), and in the Practice Note by the Ministry for Social Affairs and the Interior on the Use of Forcible Measures and other Infringements of the Right of Self-determination of Adults, including Pedagogic Principles (Practice Note No. 8 of 15 February 2011), item 107.

In 2012, the Ministry for Social Affairs and the Interior issued Practice Note on the Use of Forcible Measures in connection with Persons with a Substantial and Permanent Impairment of Mental Function – for the use of Public Officials. On page 33 of the Practice Note, the process for the treatment of reports on the use of forcible measures is described in more detail. From this it appears, among other things, that the accommodation facility shall send the report to the municipality with a duty to act for the resident and to the social supervision authority and that the municipality with a duty to act for the resident shall make a decision on the lawfulness of the measure and provide the resident with guidance on channels of complaint. There are, however, no provisions in the Social Services Act or in the above-mentioned Executive Order that say that the municipality with a duty to act shall make a decision regarding the lawfulness of the measure or provide the resident with guidance on channels of complaint.

The Ombudsman's visits showed that all the accommodation facilities – according to their own statements – send all reports on forcible measures to the municipality responsible for the resident's action plan and to the relevant social supervision authority. A number of municipal facilities also send all reports to their owner municipality, just as the regional facilities send all reports to the region. All facilities were aware that the social supervision authorities were not obliged to give any feedback concerning the individual report.

The visits also revealed that none of the visited institutions receive any feedback to all of their reports on forcible measures sent to the municipalities responsible for the residents' action plans.

The visits also showed that for the three different types of institution (private, municipal and regional) there was also a difference in the extent to which, and from which body, the institutions received feedback on their reports on use of force.

The three visited private-owned institutions received highly fluctuating feedback from the municipalities with acting authority to their reports on use of force. The private accommodation facilities send their reports to the municipality with acting authority and to the social supervision authority.

Most of the visited municipality-owned institutions received feedback from the owner-municipality to all reports concerning the municipality's own residents but often not for the citizens who were not the municipality's own residents. For some municipalities, however, the system was similar to the system described below for the regions. In those instances, the institution received feedback from the owner-municipality also to the reports regarding citizens who were not the municipality's own residents but often not from the citizen's own action plan municipality.

All regional institutions received feedback from the region to all reports, as a system has been established in the regional institutions to the effect that all reports on the use of force shall be sent not only to the action plan municipality but also to the region. According to the regional institutions' information, some of the action plan municipalities did not provide the institutions with any feedback.

All the institutions expressed a wish for feedback from the action plan municipalities to reports on the use of force. However, the institutions did not know if there was a duty on the part of the action plan municipality to give feedback on each individual report. In the institutions' opinion, feedback would strengthen the cooperation between the institution and the action plan municipality which would in many instances be a clear benefit for the citizens.

The Ombudsman will discuss the uneven practice in this field and the institutions' wish for feedback to reports on the use of force with the Ministry of Social Affairs and the Interior.

Notification and channels of complaint

Section 133 of the Social Services Act stipulates the channels of complaint for, among other things, the use of force in an urgent situation, pursuant to section 126 of the Act.

In a case published in the Ombudsman's Annual Report for 2014, 2014-2, the Ombudsman has criticised, among other things, that a municipality's decision on the use of a door opener for a resident at an institution was not notified to anyone. In the Ombudsman's opinion, the resident's spouse ought to have been informed of the

decision. The Ombudsman also stated that both the accommodation facility and the municipality should have observed the rules on, among other things, registration and reporting of and follow-up on the use of the door opener.

As mentioned above, the Ministry of Social Affairs and the Interior has specified in its Practice Note on the Use of Forcible Measures in connection with Persons with a Substantial and Permanent Impairment of Mental Function that the action plan municipality shall provide guidelines on appeal when restrictive measures have been used.

The Ombudsman's visits to individual support programmes showed an uneven practice as to whether guardians, relatives or others with the right to complain are notified when the use of force has taken place, and whether they receive guidance on the channels of complaint.

In some instances, the contact between the accommodation facility and the guardian/relatives was good, and the facility would for instance notify the guardian/relatives of the restrictive measure over the phone, but without any guidance on channels of complaint. The accommodation facilities generally did not know whether the action plan municipality gave any guidance on appeal to those with a right to complain.

In other instances, the accommodation facility saw to it that guardians/relatives were notified in writing and given guidance on channels of complaint.

In yet other instances, certain owner municipalities saw to it that guardians/relatives were notified when a restrictive measure had been carried out and gave them guidance on channels of complaint. In those instances, however, the accommodation facility had no knowledge of whether or not guardians/relatives of citizens from other municipalities than the owner-municipality received notification and guidance on channels of complaints.

The visiting team's talks with guardians/relatives showed that the majority received notification (via the telephone or in connection with visits) from the accommodation facility of a restrictive measure.

The talks also showed that only very few – according to their own memory – had received notification and guidance on channels of complaint from the action plan municipality concerning the restrictive measure.

The Ombudsman will discuss the uneven practice in the sector with the Ministry of Social Affairs and the Interior with a view to ensuring that relatives, spouses, guardians, etc. can in practice utilise the channels of complaint according to section 133(3) of the Social Services Act.

Copenhagen, 12 May 2016

Jørgen Steen Sørensen

Danish Parliamentary Ombudsman

Appendix 1

The Ombudsman's visits to individual support programmes in 2015

Institution	**Date**	**Number of residents**
"Damsgaarden"	25 March	1
"Udviklingsprojektet De 2 Gårde"	9 April	5
"Birkekrattet"	10 April	1
"Atterbakken"	28 April	1
"CAS 2"	29 April	3
"Sødisbakke"	19 and 20 May	25
"Sølund"	3 and 4 June	18
"Solkrogen"	17 June	3
"Behandlingscenteret Hammer Bakker"	18 June	6
"Ørum Bo- og aktivitetscenter"	27 August	3
"Hyldgården"	28 August	3
"Stokholtbuen"	2 September	6
"Rønnegård"	17 September	3
"Solvognen"	21 September	1
Total of 14 institutions		**79 residents**

FOLKETINGETS OMBUDSMAND

Thematic Report 2015 on children and young persons at institutions for the disabled

Doc. No. 16/01412-3
IRL/MJE

What has the theme led to?

Children and young persons attending or residing at institutions due to their extensive and permanent functional impairment were one of the themes for the monitoring visits which the Ombudsman carried out in the children's social care sector in 2015 in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

It was the Ombudsman's overall assessment that the staff at the institutions were generally reflective in relation to the many practical and ethical dilemmas of everyday life and that they were caring and development-oriented towards the children and young persons.

On the basis of his monitoring visits, the Ombudsman generally recommends that institutions, where children and young persons due to their extensive and permanent functional impairment are attending or residing, draw up written guidelines on how the institution prevents sexual abuse and which procedure the institution follows if there is suspicion of abuse.

The Ombudsman is going to discuss the follow-up of this general recommendation with the Ministry of Social Affairs and the Interior, the National Board of Social Services and the social supervision authorities. In addition, the Ombudsman is going to follow up on the recommendation during his monitoring visits.

The Ombudsman is also going to discuss with the Ministry of Social Affairs and the Interior, the National Board of Social Services and the social supervision authorities whether there is a need to extend the knowledge of – and in this connection communicate on an ongoing basis – the development of the IT assistive aids which can support the communication of children and young persons with limited verbal or non-verbal language.

Furthermore, the Ombudsman is going to discuss the problem of the dilemmas between force and care with the Ministry of Social Affairs and the Interior and the Ministry of Health.

The Ombudsman has sent this report to the Ministry of Social Affairs and the Interior, the National Board of Social Services, the social supervision authorities and the Ministry of Health with the purpose of drawing the authorities' attention to the report in order for it to form part of their deliberations in this sector. The report is also sent to

the institutions which the Ombudsman visited as part of this theme. Moreover, the Ombudsman has informed the Legal Affairs Committee, the Domestic and Social Affairs Committee and the Health Committee of this report.

Please read more about the Ombudsman's work on various themes in the appendix to this report.

Reasons for the choice of theme

Children and young persons who, due to their extensive and permanent functional impairment are attending or residing at institutions, may because of their disability find it difficult themselves to make use of the general services and help that exist for children and young persons. This can for instance be using the Children's Telephone (the chat line at the NGO "Børns Vilkår") or contacting the Ombudsman's Children's Division. Therefore, the Ombudsman chose these children and young persons as a theme for his monitoring visits.

Choosing this theme, the Ombudsman wanted to gain an increased insight into and to assess the conditions of these children and young persons.

The investigation took as its point of departure some of the general focus areas which the Ombudsman has during his monitoring visits. Generally, the Ombudsman focuses for instance on forcible measures. The Ombudsman also generally focuses on the users' relationship, for instance the relationship between the children and young people living at institutions and their families and the institution's staff.

The Ombudsman's monitoring visits are particularly aimed at society's most vulnerable citizens. The group of vulnerable citizens are, among other things, characterised by having very few resources, meaning that their rights can easily be put under pressure. This may also apply to children and young persons with extensive and permanent functional impairment.

The children and young persons whom the Ombudsman met during his monitoring visits suffered from various rare syndromes, chromosome disorders and severe brain damage. Most of the children and young persons had a severe mental disability and no or limited verbal language.

What did the Ombudsman do?

The theme was relevant at 10 out of the 11 monitoring visits which the Ombudsman carried out in the children and young persons social care sector.

The theme had the following topics:

- The Ombudsman visited institutions in all five regions: The institutions included one private, seven regional and two municipal institutions. They were 24-hour residential institutions, respite institutions, day-care facilities and an accommodation facility.

- In advance, the Ombudsman asked the institutions:

    - to write a list of the children and young persons at the institution with information about the individual child's and young person's means of communication and communication skills
    - to give information about the number of cases of abuse, violence and threats during the last three years, both between the children and the young persons, by the adults towards the children and young persons, and by the children and young persons towards the staff
    - to give information about guidelines on prevention and processing of cases involving violence and abuse (policy on violence, etc.).

- The talks which the Ombudsman's visiting team had with the management, staff, relatives, children and young persons at the institutions, focused, among other things, on the well-being of the children and young persons who, due to their extensive and permanent functional impairment, were attending or residing at institutions.

In order to get insight into the communicative challenges and difficulties of this group of children and young persons, the Ombudsman visited the private national association "LEV" (in Danish 'Live') in the beginning of 2015. During the visit at "LEV", the Ombudsman was introduced to various ways of communication with children and young persons with limited or no verbal language and to alternative and supportive methods of communication.

The monitoring visits were carried out as part of the Ombudsman's general monitoring activities pursuant to section 18 of the Ombudsman Act and as part of the

Ombudsman’s task of preventing exposure to for instance inhuman or degrading treatment of persons who are or may be deprived of their liberty, cf. the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The Ombudsman's work to prevent degrading treatment, etc. pursuant to the Protocol is carried out in cooperation with the Danish Institute for Human Rights and with DIGNITY – Danish Institute Against Torture. DIGNITY and the Institute for Human Rights contribute to the cooperation with special medical and human rights expertise, meaning among other things that staff with this expertise participate in the planning and execution of and follow-up on monitoring visits on behalf of the two institutes.

The Ombudsman has a special responsibility to protect children’s rights in accordance with, among other things, the UN Convention on the Rights of the Child. The Ombudsman’s Special Advisor on Children’s Issues participates in monitoring visits to the children and young persons social care sector.

What did the Ombudsman find?

Based on his monitoring visits, the Ombudsman noted the following, among other things:

- The Ombudsman’s overall impression was that the staff at the institutions were generally reflective in regard to the many practical and ethical dilemmas of everyday life as well as being caring and development-oriented towards the children and young persons.
- None of the institutions had written guidelines on how the institution prevented sexual abuse and which procedure the institution would follow if there was suspicion of abuse.
- The institutions were generally concerned with and attentive to the communication with the children and young persons and also the various ways in which the children and young persons communicated.
- The institutions differed widely in their awareness of IT developments regarding communication-supportive aids which can help children and young persons with a limited or non-verbal language.
- Every institution faced dilemmas on a daily basis, especially on the relationship between force and care.

Guidelines regarding sexual abuse

In accordance with Article 34 in the UN Convention on the Rights of the Child, Denmark has accepted to protect the child against all kinds of sexual exploitation and sexual abuse.

None of the institutions had written guidelines on how the institution prevented sexual abuse and which procedure the institution planned to follow if there was suspicion of abuse.

By far the main part of the children and young persons who lived at the institutions had a mental formative age which did not correspond to their physical age due to their functional impairment. As an example, the Ombudsman's visiting team met a tall, young man in his late teens. His physical development matched his age, also sexually, but his mental age was approx. 2-5 years, and his verbal language was very limited. In addition, the visiting team met a young woman who was also in her late teens and with the mental age of approx. 1½ years and with no verbal language. She was very attracted to men and sought physical contact with the boys and men she met.

The institutions generally paid attention to teaching the children and young persons appropriate sexual behaviour. However, because of the functional impairment and the limited or lacking (verbal) language, it was almost impossible for the main part of the children and young persons to say no to others.

None of the institutions could report any specific incidents of sexual abuse. On some occasions, the staff had noticed a behavior in the young persons which had been regulated by the staff in cooperation with the parents in order to safeguard the young persons themselves as well as ensuring that the young persons' interrelations were reciprocal and voluntary. The regulation might for example be that the young persons were not allowed to spend time together in a room without supervision.

The visits showed that the staff were generally not sure whether they would find out if a child or young person had been subjected to abuse.

According to the Crime Prevention Board's (Det Kriminalpræventive Råd) report *Sexual Violence amongst Young Persons: A Systematic Approach to Primary Prevention* (March 2012), studies show that children and young persons with disabilities are at an increased risk of sexual abuse, among other things because of the functional impairment which make them easy prey to offenders.

Based on his monitoring visits, the Ombudsman generally recommends that institutions, where children and young persons due to their extensive and permanent functional impairment are attending or residing, draw up written guidelines on how the institution prevents sexual abuse.

When drawing up the guidelines, it may be advisable that the institution thoroughly considers the situations where children and young persons may be subjected to abuse from other children and young persons, from the institution's staff or from persons outside the institution.

The guidelines may, among other things, describe procedures for preventing the child and young person being subjected to abuse but also to prevent the staff from baseless accusations of abuse. The procedures can, for example, counterbalance the regard for preventing abuse with the regard for respecting the child and young person when they need help with intimate hygiene such as bathing and diaper change.

The Ombudsman also recommends that the institutions draw up written guidelines on how the institution prevents sexual abuse and which procedure the institution follows if there is suspicion of abuse.

The Ombudsman is going to discuss the follow-up of this general recommendation with the Ministry of Social Affairs and the Interior, the National Board of Social Services and the social supervision authorities. In addition, the Ombudsman is going to follow up on the recommendation during his monitoring visits.

Supportive methods of communication

Article 12(1) in the UN Convention on the Rights of the Child stipulates that a child who is capable of forming his or her own views has the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

According to Article 7(3) in the UN Convention on the Rights of Persons with Disabilities, a child with a disability has the right to express its views in all matters affecting the child on an equal basis with other children, the views of the child being given due weight in accordance with the age and maturity of the child, and to be provided with disability and age-appropriate assistance to realise that right.

In practice, communication forms the basis for people having a say in their own lives. For children and persons with disabilities, the access to get help and assistance to communicate can be crucial when it comes to them actually getting this right and influence.

Many of the children and young persons, whom the Ombudsman met during his monitoring visits, had no or very limited (verbal) language. These children and young persons were dependent on others compensating for their lacking or limited ability to talk and being able to interpret the children's and the young persons' communicative utterings.

The institutions were generally concerned with and attentive to the communication with the children and young persons and also with the various ways in which the children and young persons communicated.

The visiting team encountered these ways of communication, among other things:

- Some children were able to use 'Signs to Speech' ("Tegn til Tale") where the verbal language is supplemented with hand signs.
- Some children were able to use images so that the communication took place when the child pointed at images of an activity or of something the child wanted.
- Some children solely communicated using eyes, sounds and/or facial expressions.
- One institution recorded videos of the individual child in order to be able to analyse the child's communication method.
- At some institutions, it was possible for the children and young persons to have a regular and ongoing contact with their families using Skype or FaceTime.
- At most of the institutions, the children had a 'communication passport' which is a small, laminated booklet containing a description of the child and its needs plus a description of the child's communication methods. Please find more information (in Danish only) on "kommunikationspas" on the National Board of Social Services' homepage (www.socialstyrelsen.dk).
- One institution had QR codes on the children's wheelchairs, stands and walkers. When scanning the codes on the institution's iPads, information about the child and short film clips were shown on, for example, how to tuck the child in and how the child communicated, etc.
- In one institution, the common room had a big touch screen which enabled the children – either individually or together – to choose from activities such as learning games, music and films.

These ways of communicating can serve as inspiration.

The institutions differed widely in their awareness of IT developments regarding communication-supportive aids which can help children and young persons with a limited or non-verbal language.

The Ombudsman is going to discuss with the Ministry of Social Affairs and the Interior, the National Board of Social Services and the social supervision authorities whether there is a need to extend the knowledge of – and in this connection communicate on an ongoing basis – the development of the IT assistive aids which can support the communication of children and young persons with limited verbal or nonverbal language.

Dilemmas between force and care

All the visited institutions faced dilemmas on a daily basis, especially concerning the balance between force and care. Typically, it was in situations where the children and young persons as a result of their functional impairment did not understand the consequence of a measure or the consequence of own actions and where legislation does not generally allow the use of force.

One dilemma, which the visiting team were informed of, was that the child or young person maybe wanted to leave the institution and could do so because of an unlocked main entrance door, but the child/young person was not able to cope outside the institution, neither in traffic, nor in encounters with other people. Another dilemma dealt with a young person who exposed himself/herself outside the institution. There were also examples of situations with the child or young person opposing blood sampling or vaccination or the brushing of teeth.

The issue is mentioned in legislative report No. 1551/2015 on use of force towards children and young persons who are placed outside the home. The legislative report has been followed up by a legislative proposal on the responsibility of adults towards children and young persons in care (L 162, proposed on 30 March 2016, Folketinget 2015-16).

Similar dilemmas are found in the adult social care sector.

The Ombudsman informed the Ministry of Health of the dilemmas in a meeting on 19 January 2016.

The Ombudsman is going to discuss the issue with the Ministry of Social Affairs and the Interior and with the Ministry of Health.

Copenhagen, 21 April 2016

Jørgen Steen Sørensen

Themes for monitoring activities 2015

Dok.nr. 16/01412-4/RI/SOS

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

The choice of themes is particularly dependent on which areas are in need of an extra monitoring initiative. The Ombudsman will often select a narrow theme, such as for instance the Prison and Probation Service's use of security cells. Other times, the Ombudsman will select broad themes, such as for instance children and young people who, due to a substantial and permanent impairment of their physical or mental function, attend or reside at an institution

The themes give the Ombudsman the opportunity to include current topics in his monitoring activities and also to make in-depth and transverse investigations of particular problematic issues and to gather experience about practice, including best practice.

A principle aim of any year's monitoring visits is to shed light on and investigate the year's themes. The majority of the year's monitoring visits will therefore go to institutions where the chosen themes are relevant.

Thematic reports

At the end of the year, the Ombudsman, together with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture, reports on the outcome of the year's monitoring activities.

The themes are especially reported in separate reports on the individual themes. In these reports the Ombudsman sums up and imparts the most important results of the themes.

General recommendations

Results of the themes may be general recommendations to the authorities, such as for instance a recommendation to draw up a policy for the prevention of violence and intimidation between the users/residents.

General recommendations are based on the Ombudsman's experience of the field in question. Usually, they will also have been given as concrete recommendations to particular institutions during previous monitoring visits.

Typically, the Ombudsman will discuss the follow-up to his general recommendations with the central authorities. In addition, the Ombudsman will follow up on the recommendations during monitoring visits.

The general recommendations have a preventive aim. The basis for the preventive work in the monitoring field is that the Ombudsman has been appointed national preventive mechanism (NPM) according to the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The thematic reports will be published on the Ombudsman's homepage, www.ombudsmanden.dk. In addition, the Ombudsman will send the reports to all relevant authorities so that the authorities can include the reports in their deliberations regarding the various sectors.