THE DANISH
PARLIAMENTARY
OMBUDSMAN

Monitoring Activities 2017

Extracts from the Annual Report of the Danish Parliamentary Ombudsman

PREFACE

This publication contains an extract of the pages from the 2017 Annual Report of the Danish Parliamentary Ombudsman which relate specifically to the Ombudsman's monitoring activities.

The extracted material on pages 30-75 is unchanged from the Annual Report, and the original pagination has been maintained.

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

The 2017 Annual Report of the Danish Parliamentary Ombudsman can be read in full on www.ombudsmanden.dk or obtained in book form from the Ombudsman's office.

RESIDENTIAL FACILITIES IN THE SOCIAL PSYCHIATRIC SECTOR MUST BE SAFE – ALSO FOR RESIDENTS

Recent years have seen tragic cases of deaths, violence and threats at Denmark's residential facilities, and this has put more focus on staff safety. But are the facilities safe for the individual residents, and do the residents feel safe? The Ombudsman decided to look into this at his monitoring visits in 2017.

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On a day in the spring of 2017, a small team from the Ombudsman's office are on a monitoring visit to a residential facility on the outskirts of a Danish provincial town. The facility consists of separate houses with individual flats for the residents and a shared community room with a kitchen, television and sofa corner. During our tour of one of the houses, we run into a large man with a beard. He is standing in the middle of the floor in the community room, shouting angrily. We have to get quite close to the man in order to pass. Even though his anger is probably not directed towards us, he still seems scary to the whole team.

The man with the beard is called Ole. We have read about him beforehand in the material we always ask for prior to a monitoring visit. In the material, he is described as temperamental. Ole is 61 years old and has been living at the facility for almost three years because he needs extensive daily support. He is an alcohol abuser, has a record of violence and threats, and over a number of years he has regularly been hospitalised in psychiatric wards. In that way, Ole is similar to many other residents at the country's social psychiatric residential facilities. At Ole's facility, all residents have a psychiatric diagnosis, and almost a quarter of the residents have a hospital order.

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THE OMBUDSMAN'S MONITORING VISITS

- Monitoring visits are an important task for the Ombudsman. Besides handling complaints and taking up cases on his own initiative, the Ombudsman carries out approximately 50 monitoring visits each year.
- The Ombudsman's visiting teams visit public and private institutions, especially institutions where persons are or may be deprived of their liberty, for instance prisons, social care institutions and psychiatric wards.
- The objective of the monitoring visits is to contribute to ensuring that persons who are staying or living at institutions are treated with dignity and care and in accordance with their rights.

RESIDENT SAFETY OVERLOOKED

Ole is not interested in talking with us, but his fellow residents tell us that he sometimes has outbursts with him shouting, behaving in a threatening way and smashing things to pieces. This makes them feel unsafe. Another resident, who is called Pia, tells us about an incident when Ole wreaked havoc in the community room and knocked things down from the dining table. This incident has made Pia afraid of Ole. Pia tells us that she now goes into her own room to eat even though she really prefers to sit in the community room with the other residents.

Late in the day, we speak with management, and we make a number of recommendations based on what we have seen and heard throughout the day. Among other things, we suggest that management draw up a policy on how to prevent, handle and follow up on violence, threats and other incidents which cause feelings of unsafety, just like the anti-violence policy for staff that is already in place. The management agree that when an anti-violence policy for staff exists, there ought to be one for residents too, of course.

The reaction is quite typical of our visits to residential facilities in 2017: there is agreement that residents' perspective may have been overlooked in the efforts to improve the safety of staff.

Through recent years, a number of tragic deaths have taken place: staff have been attacked by residents at social psychiatric residential facilities throughout the country. The attacks have attracted great attention, and in the wake of the debate, staff safety has been improved. For example, the Danish Working Environment Authority issued improvement notices in 2016 to many institutions in the social psychiatric sector, requiring among other things that knives were not to be freely accessible at residential facilities, that staff must carry personal attack alarms and that staff were not to work on their own.

THE PSYCHIATRIC SYSTEM

- Hospitals (open and closed general psychiatric wards and closed forensic psychiatric wards): examination, diagnosis and treatment.
- Community mental healthcare sector: psychiatric treatment on an outpatient basis.
- Social psychiatric sector: all kinds of everyday support other than medical treatment to citizens with mental health issues. Includes residential facilities, drop-in centres and support person programmes. It is the municipality's responsibility to provide social psychiatric programmes, either its own programmes or in cooperation with other municipalities or regions or private programmes (cf. section 4(1) and (2) of the Social Services Act).

However, the debate has almost solely been about staff safety. Therefore, the Ombudsman decided to take a closer look at resident safety as a general theme for his monitoring visits in 2017.

The theme on the social psychiatric sector consisted of two sub-themes: safety for citizens at residential facilities and cooperation between residential facilities and psychiatric wards.

THE FRIGHTENED NEIGHBOUR

Mostly, monitoring visits start with the monitoring team having a morning meeting of a couple of hours' duration with the facility's management, who show us around at the facility afterwards. In the afternoon, we talk with staff members, residents and any relatives who are interested in a talk. We make a point of talking with as many residents as possible in order to obtain the most true and balanced picture of the institution. In 2017, we visited 13 psychiatric residential facilities and talked with a total of 75 residents.

During our visit to another residential facility, management tell us about an incident which took place a few weeks prior to our visit. For some months, two residents, Søren and David, have been provoking each other. Søren, who is 40 years old, and David, who is 34 years old, have been living at the facility for six and eight years, respectively. Both have hospital orders and extensive alcohol and drug abuse problems, and both can look back at numerous hospitalisations within the psychiatric sector.

After having been hospitalised for a couple of days, Søren has now been discharged from the psychiatric ward once again. At the residential facility, however, they do not think that Søren was ready for discharge, and in the days after the discharge, Søren's behaviour has been quite erratic. This culminates three days after the discharge when Søren threatens to kill David and chases him with a butter knife. The staff dial 112 (for emergency services) and manage to get the two separated. After the staff have withdrawn, Søren is still agitated. He gets hold of two golf balls, throws them at a car belonging to one of the staff members and smashes the windscreen. When the police arrive an hour and thirty minutes after the call, Søren has calmed down, but the police take him along after all, and he is hospitalised at a psychiatric ward.

While this incident takes place, Søren's neighbour Lars has been told by staff to stay in his room and lock the door. During our visit, we talk with Lars. He tells us that he often locks himself in his room when Søren goes berserk – and

that it happens approximately every three weeks. The frequent fits of rage make Lars feel very unsafe. He never knows how Søren will react after the hospitalisations. Lars wishes that the staff would talk with him about what he should do in regard to Søren.

RECOMMENDATIONS ON AN ANTI-VIOLENCE POLICY IN WRITING

During the meeting with management, the monitoring team are told that crisis counselling for staff was ordered immediately after the incident with Søren, and that calls to involved staff members are made on a daily basis to make sure they are doing all right. But when we get talking about a follow-up for David, Lars and the other residents, management cannot account for what action was taken, and there is no information in the facility's records either. As agreed with Lars, we tell management how Lars experienced the incident, and that he felt that he needed a follow-up afterwards. Management appreciate being made aware of this. As we did at Ole's residential facility, we recommend that the facility draw up an anti-violence policy in writing with guidelines on follow-ups with residents after crisis situations.

At many of our visits, we saw the same as we saw at the two facilities described above: the residential facilities have an anti-violence policy to support staff but nothing in writing when it comes to violence and threats among residents. Therefore, we recommended at a total of seven facilities that management draw up a written anti-violence policy with guidelines on how to support residents in the event of violence end threats.

In addition, at five residential facilities, we recommended keeping records of incidents involving violence and threats among residents and using these records as preventive measures, among other things in order to find causes and patterns in the occurrence of violence and threats. The purpose of the records and analyses of these records would be to put focus on resident safety and to contribute to staff getting better at preventing incidents involving violence and threats.

KEY INITIATIVES

During our visits, at least one resident at all of the facilities reported that he or she would sometimes feel unsafe. Looking back at the year's visits to social psychiatric facilities, our conclusion is that the effort to ensure residents' safety and feeling of safety should be strengthened. In the Ombudsman's assessment, it is crucial that all residential facilities get an anti-violence policy and specific

guidelines which do not only cover staff but also threats and violence directed at other residents.

At the same time, however, it is important to point out that our impression is that the residential facilities are making great efforts already. In general, the residents we talked with said that they liked and felt safe around the staff. In this way, the residential facilities have a good basis for improving residents' safety and feeling of safety.

The outcome of this year's visits to residential facilities will be discussed at meetings with both the Ministry for Children and Social Affairs and the Ministry of Health in the spring of 2018. The objective of these discussions is to assess whether the formulation of guidelines within the social psychiatric sector can be done centrally with the ultimate intent to improve residents' safety and feeling of safety.

All names of residents mentioned in the article have been changed.

The outcomes of the year's monitoring visits to 13 residential facilities have been gathered in a thematic report (in Danish only), which can be found at www.ombudsmanden.dk/tilsyn. Please find more information about the Ombudsman's activities in the monitoring field on pages 36-75.

THEME ON THE SOCIAL PSYCHIATRIC SECTOR

The social psychiatric sector was chosen as the theme for monitoring visits carried out in 2017 by the Ombudsman to institutions for adults in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

The theme consisted of two sub-themes:

- Resident safety at social psychiatric residential facilities
- Sector transfers and cooperation between social psychiatric residential facilities and the psychiatric sector

Out of a total of 40 monitoring visits to institutions for adults, the Ombudsman visited 13 social psychiatric residential facilities and seven psychiatric wards in connection with the theme for 2017.

The criteria which the 13 residential facilities selected by the Ombudsman had to meet included being temporary or long-term residential facilities covered by section 107 or section 108 of the Social Services Act and their target group consisting, among others, of persons with hospital orders and persons with dual diagnoses (a mental health illness combined with a substance abuse problem).

Please find more information about the theme, including the Ombudsman's conclusions and recommendations, on page 38.

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 prisons, social care institutions and psychiatric wards.

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

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

The Ombudsman has a special responsibility to protect the rights of children under the UN Convention on the Rights of the Child, etc.

How: During monitoring visits, the Ombudsman often gives recommendations to the institutions. Recommendations are typically aimed at improving conditions for users of the institutions and in this connection also at bringing conditions into line with the rules. Recommendations may also be aimed at preventing, for example, degrading treatment.

Monitoring visits may also cause the Ombudsman to open investigations of general problems.

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

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

MONITORING ACTIVITIES – ADULTS

THEME FOR 2017

The social psychiatric sector – with focus on

- safety for residents at social psychiatric residential facilities
- sector transfers and cooperation between residential facilities and the psychiatric sector

The Ombudsman's monitoring teams visited 13 social psychiatric residential facilities and seven psychiatric wards in connection with the theme for 2017.

Important conclusions

- At all residential facilities visited, at least one resident felt unsafe at times due to other residents' behaviour.
- Cooperation agreements between the individual residential facility and the psychiatric sector have a good effect.

The Ombudsman generally recommends

- that social psychiatric residential facilities systematically record incidents involving violence and threats among residents and that they analyse data for the purpose of prevention etc.
- that social psychiatric residential facilities draw up written guidelines on how to handle violence and threats among residents (anti-violence policies)
- that social psychiatric residential facilities systematically record admissions to and discharges from psychiatric wards which they consider undesirable
- that cooperation agreements are made between social psychiatric residential facilities/the municipality and the psychiatric treatment sector/the region about admissions, hospital stays and discharges

Specific recommendations (extracts) can be found in the table on pages 42-53.

Reports on the themes for our monitoring visits in recent years can be found at www.ombudsmanden.dk by clicking the globe icon, selecting 'English' and choosing the heading 'Publications'. Please also read the article 'Residential facilities in the social psychiatric sector must be safe – also for residents' on pages 30-35.

CASES CONCLUDED IN 2017 IN RELATION TO MONITORING ACTIVITIES

67 cases about suicide attempts, deaths etc. at Prison and Probation Service institutions or among persons in police custody

None of the cases gave rise to criticism.

19 cases opened by the Ombudsman on his own initiative (12 of which were opened in direct continuation of monitoring visits)

Seven cases resulted in criticism and/or formal recommendations.

Selected cases opened by the Ombudsman on his own initiative in connection with monitoring visits

Conditions for mentally ill inmates were investigated: The Ombudsman carried out an investigation of conditions for inmates of a special prison unit for mentally ill inmates, especially their possibilities for participating in occupational and other activities. When the Ombudsman was informed by the authorities about definite improvements of their conditions, he concluded the case without criticism. (News story published on 11 January 2017).

The rules on door and window alarms were not observed at a residential facility (three cases): Various types of alarms had been used at the housing units of a number of residents at a municipal residential facility without observance of the relevant rules. The Ombudsman criticised the municipality's course of action, and the municipality tightened up its procedures. (Case No. 2017-9 and news story published on 29 March 2017).

Reports on placements in security cells were inadequate: The Ombudsman criticised the Prison and Probation Service in two cases in which inmates were placed in security cells (and typically forcibly restrained to a bed). In one of the cases, an inmate had been in a security cell for more than four days and nights. The Ombudsman assessed that the reports on the placements were inadequate, and he also criticised several other matters in the cases. The Prison and Probation Service would undertake various improvement initiatives. (Case No. 2017-18 and news story published on 21 August 2017).

Regime of checking residents' mail was criticised: The Ombudsman criticised a regime of checking letters and parcels received by residents at a secure institution, and he recommended that the regime be discontinued. The institution took note of the Ombudsman's recommendation. The Minister for Children and Social Affairs has subsequently introduced a bill (L 119/17) which contains rules, among others, on checks of mail. (Case No. 2017-27 and news story published on 6 September 2017).

Safety in unstaffed police detention facilities in Greenland was improved: The safety of persons placed in police detention facilities in Greenland which are not permanently staffed has been significantly improved. However, some aspects of their safety still give cause for concern. That was the Ombudsman's conclusion after extensive dialogue with the authorities in charge following a monitoring visit to Greenland in 2013 which included unstaffed detention facilities. (Case No. 2017-33 and news story published on 9 March 2017).

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WHERE DID WE GO IN 2017?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
	40 visits in total		**306 talks**	**40 talks**	**35 visits**	**19 visits**	
16 Jan.	'Psykiatrisk Center København', Bispebjerg	Emergency admission unit and bed unit for general psychiatric patients	5	1		✓	
18 Jan.	'Psykiatrisk Center København', Rigshospitalet	Two bed units for general psychiatric patients	4	1			
25 Jan.	'Søbysøgård Fængsel', Årslev	Closed section in an open prison, particularly for persons serving time	11	0	✓		
26 Jan.	'Nyborg Fængsel'	Closed section particularly for 'negatively strong' persons serving time and arrestees	6	0	✓	✓	
2 Feb.	'Maribo Arrest'	Local prison particularly for persons remanded in custody during investigation of their case	10	0	✓		
3 Feb.	'Nykøbing Falster Arrest'	Local prison particularly for persons remanded in custody during investigation of their case	9	0	✓	✓	

1) The Ombudsman collaborates with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights (IMR) on monitoring activities. Among other things, they participate in a number of monitoring visits.

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

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

	Selected recommendations etc.[4]
	Visits concluded with recommendations: 38 **Visits concluded without comments: 0** **Not concluded at the time of going to press: 2**
	– Ensure medical assessment at least three times a day in connection with forcible physical restraint – Ensure an external physician undertakes an assessment of forcible restraint if it lasts more than 24 hours
	– Ensure the anti-violence policy contains clear information about prevention of physical and mental violence among patients – Analyse why most incidents with sedatives involving coercion have occurred during the summer months for a number of years – Keep records of use of coercion with information about grounds and names of staff involved
	– Give guidance to inmates about body searches and urine sampling and follow up on whether they are carried out in accordance with the rules
	– Give guidance to inmates about body searches and urine sampling and follow up on whether they are carried out in accordance with the rules *Case opened on the Ombudsman's own initiative regarding 14 reports on placements in security cells. Concluded without criticism based on a statement and initiatives from the Prison and Probation Service.*
	– Give guidance to inmates about body searches and urine sampling and ensure that, and follow up on whether, they are carried out in accordance with the rules – Increase focus on inmates' right to an initial medical examination and remand prisoners' right to call in their own doctor – Exercise greater care when completing consent forms for sharing medical information *Case opened on the Ombudsman's own initiative about an incident involving use of force in connection with the use of pepper spray.* *The case was still pending at the time of going to press.*
	– Give guidance to inmates about body searches and urine sampling and ensure that, and follow up on whether, they are carried out in accordance with the rules – Inform inmates about their contact person and ensure regular contact between contact person and inmate – Increase focus on thorough and informative arrival interviews and the use of interpreters at the interviews – and otherwise to the extent necessary

4) The table contains selected, abbreviated recommendations. The full recommendations can be found (in Danish only) at www.ombudsmanden.dk, where concluding letters on monitoring visits are published on an ongoing basis. The table also includes information about cases taken up on the Ombudsman's own initiative following monitoring visits.

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WHERE DID WE GO IN 2017?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
9 to 10 Feb.	'Psykiatrien Slagelse', forensic psychiatric ward	Three bed units for forensic psychiatric patients	15	2			
27 Feb.	'Asylcenter Segen', Bornholm	Accommodation centre particularly for single male asylum seekers awaiting the processing of their case	5	0	✓		
28 Feb.	'Bornholm Arrest', Rønne	Local prison particularly for persons remanded in custody during investigation of their case	4	0	✓		
8 Mar.	'Botilbuddet Røde Mellemvej', Copenhagen	Municipal social psychiatric residential facility for adults with combined problems	12	2	✓	✓	
9 and 24 Mar.	'Botilbuddet Robert Jacobsens Vej', Bagsværd	Municipal social psychiatric residential facility for adults with a mental disorder combined with substance abuse	7	1	✓	✓	
15 Mar.	'Østergården', Rude	Municipal social psychiatric residential facility for adults with combined problems	5	5	✓	✓	
27 Mar.	'Renbæk Fængsel', Skærbæk	Three closed prison sections particularly for persons serving time, including an isolation unit	9	0	✓		
28 Mar.	'Botilbuddet Skovsbovej', Svendborg	Municipal social psychiatric residential facility for adults needing specialised treatment 24 hours a day	8	4	✓		

	Selected recommendations etc.[4]
	– Carry out further analysis of patterns and reasons behind the use of coercion, including comparison with other, similar wards – Change the house rules so that the wording about opening patients' mail reflects the condition of suspicion pursuant to the Mental Health Act – Ensure that patients are given guidance on channels of complaint in a way which is adapted to practical conditions at the units, for example in relation to internet access
	– Add information to the house rules about consequences of violations – Extend local directions on the use of force
	– Label measured out medicine with name and civil registration number – Update house rules in accordance with applicable regulations – Give guidance to inmates about body searches and urine sampling and ensure that, and follow up on whether, they are carried out in accordance with the rules
	– Record incidents involving violence and threats among residents and follow up with a view to documentation, knowledge and learning – Clarify applicable regulations in relation to the municipality's feedback to the residential facility on reported incidents involving use of force
	– Same recommendations as those given at visit on 8 March – Draw up house rules – Intensify focus on handling of medicines and in this connection ensure that staff have the necessary qualifications – Follow up systematically on inadvertent incidents
	– Draw up house rules – Draw up written guidelines on handling of violence and threats among residents (anti-violence policy) – Record incidents where staff found that residents should have been admitted to a psychiatric ward and of discharges perceived to be undesirable – Enter into a cooperation agreement with the psychiatric sector about admissions and discharges, among other things
	– Give guidance to inmates about body searches and urine sampling and ensure that, and follow up on whether, they are carried out in accordance with the rules
	– Draw up an anti-violence policy for residents as well as for staff – Draw up house rules – Give guidance on how complaints about the use of force can be made via a spouse, relative, guardian or another representative where residents are unable to complain themselves – Enter into a cooperation agreement with the psychiatric sector about admissions to, stays in and discharges from psychiatric wards

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WHERE DID WE GO IN 2017?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
3 Apr.	'Lindegårdshusene', Roskilde (**unannounced** visit)	Municipal social psychiatric residential facility for adults with mental and social challenges	8	0	✓	✓	
6 to 7 Apr.	'Psykiatrien Slagelse', Sikringsafdelingen (Maximum Security Unit)	Maximum security psychiatric bed unit particularly for psychiatric patients who are conviction placed or placed on order for compulsory admission to a mental hospital	15	1	✓		
26 Apr.	'Hillerød Arrest' (**partly announced visit**)[5]	Local prison particularly for persons remanded in custody during investigation of their case	6	0	✓	✓	
26 Apr.	'Botilbuddet Teglgårdshuset', Middelfart	Municipal social psychiatric residential facility for adults with severe social psychiatric problems and substance abuse	2	2	✓	✓	
27 Apr.	'Psykiatrisk Afdeling Svendborg'	Two bed units for general psychiatric patients	3	2	✓		
3 May	'Åkandehuset', Højby	Private social psychiatric residential facility for adults	4	4	✓	✓	
8 May	'Aarhus Universitetshospital', Risskov (**unannounced** visit)	Bed unit for general psychiatric patients	4	0	✓		

5) 'Partly announced visits' (introduced in 2017) are visits where the institution is informed that the Ombudsman will carry out a monitoring visit within a specific period – for example within one month – but not exactly when.

	Selected recommendations etc.[4]
	– Keep statistics of the occurrence of violence and threats among residents and analyse data on an ongoing basis to detect causes and patterns
	– Systematically analyse records of use of coercion to detect causes and patterns – Ensure that checks of mail are carried out in accordance with regulations – Establish a system which provides information about the duration of coercive measures – to track developments *Case opened on the Ombudsman's own initiative about the use of body scanners and restrictions of patients' access to literature, among other things. The case was still pending at the time of going to press.*
	– Ensure that only legal forcible measures are used and ensure adequate written documentation of the use of force and other restrictive measures – Update medicine directions – and train staff in them – Explore the possibilities of healthcare professionals undertaking health screenings of new inmates – Handle unused medicines according to regulations
	– Draw up written guidelines on how to handle violence and threats among residents (anti-violence policy) – Analyse records of incidents involving violence and threats to detect causes and patterns for the purpose of prevention – Draw up local directions on the use of force – Record – for documentation and learning purposes – incidents where staff found that residents should have been admitted to a psychiatric ward and of discharges perceived to be undesirable – Enter into a cooperation agreement with the psychiatric sector about admissions to and discharges from psychiatric wards, among other things
	– Draw up guidelines on violence and threats among patients and record such incidents – Enter into cooperation agreement(s) with municipalities/residential facilities about admissions/stays/discharges – Follow up on record-keeping of use of coercion and overrulings by appeals bodies
	– Revise and extend the directions on the use of force
	– Draw up a policy on prevention of violence and threats among patients – Systematically record incidents involving violence and threats among residents and between patients and staff for documentation, knowledge and learning purposes – Enter into cooperation agreements with municipalities about, among other things, admissions and discharges (to residential facilities)

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WHERE DID WE GO IN 2017?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
18 May	'Bostedet Visborg-gaard', Hadsund	Regional social psychiatric residential facility for adults, particularly adults with dual diagnoses[6]	10	4	✓		
19 May	'Silkeborg Arrest'	Local prison particularly for persons remanded in custody during investigation of their case	5	0	✓		
22 May	'Enner Mark Fængsel', Horsens	Focus section[7] in closed prison, particularly for persons serving time, with behaviour posing a risk to others	10	0	✓	✓	
7 June	'Regionspsykiatrien Vest', Herning	Two bed units for general psychiatric patients	9	4	✓		
8 June	'Herning Arrest'	Local prison particularly for persons remanded in custody during investigation of their case	5	0	✓		
21 June	'Københavns Fængsler', Vestre Hospital (**unannounced** follow-up visit)	Prison section particularly for mentally ill persons remanded in custody during investigation of their case	14	0	✓	✓	
28 June	'Bostedet Vendelbo', Vrå (**unannounced** visit)	Private social psychiatric treatment, development and residential facility for adults with personality disorders and other mental difficulties	5	0	✓		

6) A dual diagnosis is normally defined as the co-existence of disturbances caused by the use of a psychoactive drug and other mental disturbances. At all residential facilities visited in 2017, there were residents with a dual diagnosis and/or who had been placed on probation with a condition of psychiatric treatment.

7) Special section with limited association with other inmates, particularly for inmates whose presence gives rise to a special risk of assault on fellow inmates, staff and other persons at the institution.

	Selected recommendations etc.[4]
	– Draw up a policy on the prevention of violence and threats among residents – Clarify guidelines on recording incidents involving violence and threats and on reporting them to the police – Record incidents where staff found that residents should have been admitted to a psychiatric ward and of discharges perceived to be undesirable – Enter into a cooperation agreement with the psychiatric sector about admissions and discharges, among other things
	– Ensure that inmates are briefed after searches of their cells – Remind staff to knock as a general rule before opening the door to a cell – Explore the possibilities of healthcare professionals undertaking health screenings of new inmates – Handle unused medicines according to regulations
	– Inform inmates about the procedure and criteria for assessing whether they can be transferred from the focus section – Give guidance to inmates about body searches and urine sampling and ensure that, and follow up on whether, they are carried out in accordance with the rules
	– Revise house rules – Draw up guidelines on violence and threats among patients and record such incidents *Case about special shielding of a patient opened on the Ombudsman's own initiative. The case was still pending at the time of going to press.*
	– Label medicine boxes and bottles with name and civil registration number and hand out personally prescribed medicines or send them to a pharmacy for disposal when the inmate leaves the prison – Find an approved method to access health data for inmates – Give guidance to inmates about body searches and urine sampling and ensure that, and follow up on whether, they are carried out in accordance with the rules
	Still pending at the time of going to press
	– Extend the directions on the use of force – Draw up directions on (prevention of) suicides/suicide attempts – Focus on the handling of medicines to ensure that they are handled in accordance with the applicable regulations

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WHERE DID WE GO IN 2017?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
29 June	'Bostedet Brovst'	Regional social psychiatric residential facility for adults with dual diagnoses	4	3	✓		
21 to 22 Aug.	'Sdr. Omme Fængsel'	Open prison particularly for persons serving time	22	0	✓	✓	
29 to 30 Aug.	'Center Sandholm', Birkerød	Arrival section at asylum centre, particularly for asylum seekers arriving in Denmark	17[8]	0	✓	✓	
7 Sep.	'Tangkær', Ørsted	Two sections at a regional social psychiatric residential facility for adults, particularly persons with dual diagnoses and/or sentenced to placement	6	0	✓		
8 Sep.	'Viborg Arrest'	Local prison particularly for persons remanded in custody during investigation of their case	8	0	✓		
15 Sep.	'Politigårdens Fængsel', Copenhagen	Prison with focus on remand prisoners who according to a safety evaluation require 3-4 guards when cell door is opened	3	0	✓	✓	
26 Sep.	'Psykiatrisk Afdeling Odense'	Two bed units for general psychiatric patients	4	4	✓		

8) Including five talks with minors carried out by the special advisor on children's issues of the Ombudsman's Children's Division.

	Selected recommendations etc.[4]
	– Draw up written guidelines on violence and threats among patients – Record incidents involving violence and threats among residents and analyse data – Draw up local guidelines on the use of force – Enter into a cooperation agreement with the psychiatric sector about admissions and discharges, among other things
	– Ensure availability of occupational activities for inmates excluded from association with other inmates – Increase focus on the handling of medicines and record-keeping to ensure the applicable requirements are met – No exchange of sensitive information via insecure e-mail in communication with physician – Give guidance to inmates about body searches and urine sampling and ensure that, and follow up on whether, they are carried out in accordance with the rules
	– Add information in house rules about consequences of violating the rules and about zero tolerance against violence and threats – Ensure the quality of the documentation when reporting incidents involving use of force – Extend guidelines about violence and threats among residents
	– Extend guidelines about violence and threats among residents – Ensure, for reasons of due process, that the most important rules on behaviour are available in writing and that residents receive a copy
	– Update and extend house rules, among other things with information about channels of complaint following body searches or urine sampling – Give directions to the prison's physician about fields of responsibility and duties and follow up. Ensure in this connection that the physician gives directions to his or her assistants (prison officers) – Use request forms with copies to avoid complaints, doubts etc.
	– Efforts to provide more meaningful activities and human contact for inmates who were the target group of the monitoring visit – Finalise cooperation agreement with the psychiatric sector – Intensify the effort to have a specific inmate transferred to a psychiatric ward *Case opened on the Ombudsman's own initiative about an inadequate number of places available at a psychiatric ward for persons remanded in non-prison custody during investigation of their case.*
	– Amend the house rules to bring the rules on body searches and searches of patients' belongings in line with applicable regulations – Draw up guidelines on violence and threats among patients and record such incidents

Continued next page

WHERE DID WE GO IN 2017?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
27 Sep.	'Pension Kværndrup' (**partly announced** visit)	Prison and Probation Service institution particularly for persons serving time who are in a social re-entry phase	7	0	✓	✓	
11 Oct.	'Pension Hammer Bakker', Vodskov	Prison and Probation Service institution particularly for persons serving time who are in a social re-entry phase	6	0			
12 Oct.	'Tagabo', Copenhagen	Municipal social psychiatric residential facility for adults with a minor need for support	2	0	✓	✓	
23 Oct.	'Udrejsecenter Kærshovedgård', Ikast	Departure centre for rejected asylum seekers – the monitoring visit solely focused on persons with tolerated residence status	15[9]	0	✓	✓	
25 Oct.	'Gartnervænget', Sakskøbing	Municipal social psychiatric residential facility for adults, particularly persons with dual diagnoses	2	0		✓	

9) Six of these residents had tolerated residence status and were therefore part of the target group of the monitoring visit. The other residents were rejected asylum seekers.

	Selected recommendations etc.[4]
	– Introduce procedures for clearing out the medicine cabinet
	– Update house rules
	– Continuous focus on whether residents' need for support corresponds to the target group, and relevant handling in concrete situations where individual residents cause feelings of unsafety
	The Ombudsman has asked for a statement in the case. The case was still pending at the time of going to press.
	– Draw up a policy on prevention and handling of violence and threats among residents – Record incidents where staff found that residents should have been admitted to a psychiatric ward and of discharges perceived to be undesirable – Enter into a cooperation agreement with the psychiatric sector

MONITORING ACTIVITIES – CHILDREN

THEME FOR 2017

Young persons at secure 24-hour residential facilities, local prisons and state prisons – with focus on

- seclusion and use of physical force
- schooling
- relations among the young persons (rights, composition of the group of young persons, involvement of the young persons and their personal development)

The Ombudsman's monitoring teams visited six secure 24-hour residential facilities, two local prisons and two state prisons.

Important conclusions

- Young persons are frequently placed in seclusion, and at several facilities, there is room for improvement of the way in which seclusion is handled.
- At some facilities, a connection between the staff's approach to the young persons and the use of force is seen.
- There is generally room for improvement of the recording and/or reporting of incidents involving use of force at the secure 24-hour residential facilities.
- There are various challenges in regard to conditions for young persons aged 15 to 17 years at Prison and Probation Service institutions, for example staff's knowledge of the rules applicable to these inmates and the regulation of the schooling of inmates of compulsory school age.
- The in-house schools at the secure 24-hour residential facilities have various challenges in relation to the schooling of the young persons, for example in regard to teaching the full range of subjects, exemptions from certain subjects and holding examinations.

The Ombudsman generally recommends that secure 24-hour residential facilities

- endeavour to observe the deadlines for recording and reporting incidents involving use of force
- report such incidents adequately

Specific recommendations (extracts) can be found in the table on pages 58-63.

Reports on the themes for our monitoring visits in recent years can be found at www.ombudsmanden.dk by clicking the globe icon, selecting 'English' and choosing the heading 'Publications'.

CASES CONCLUDED IN 2017 IN RELATION TO MONITORING ACTIVITIES

22 cases were opened by the Ombudsman on his own initiative (12 of which were opened in direct continuation of monitoring visits).

11 cases resulted in criticism and/or formal recommendations.

Selected cases opened by the Ombudsman on his own initiative in connection with monitoring visits

Guidelines on the use of force were revised: The Red Cross decided to revise its guidelines on the use of force at asylum centres for children when it became aware, following an enquiry from the Ombudsman, that only the provisions of the Danish Criminal Code on self-defence and *jus necessitas* apply at the centres.

Inadequate recording and reporting of incidents involving use of force: In a number of instances, a private 24-hour residential facility had not recorded incidents involving use of force individually in report forms. The facility had also failed to record the incidents within the 24-hour deadline and to immediately send the completed forms to the municipality which had placed the young person at the facility. The Ombudsman criticised the facility's inadequate recording and reporting of the incidents.

No authority for obligatory washing of clothes: A secure 24-hour residential facility consistently washed all the young persons' clothes on their arrival, even if the young persons did not want it. This was done for hygienic purposes, but also to destroy any euphoriants which might have been hidden in the clothes. The Ombudsman concluded that there was no authority for the practice and recommended that the facility discontinue it. (Case No. 2017-13 and news story published on 16 May 2017).

Action plans had not been drawn up or were inadequate (nine cases): During two monitoring visits, it was revealed that there were problems with action plans for nine children. The Ombudsman opened cases with the municipalities that had placed the children at the facilities and criticised them for not having drawn up action plans and/or revised them. He also criticised the failure of some of the municipalities to provide the facilities with copies of relevant parts of the action plans. The cases are two out of 26 investigated by the Ombudsman about action plans for children. (News story published on 17 January 2018).

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WHERE DID WE GO IN 2017?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
	12 visits in total		**80 talks**	**44 talks**	**9 visits**	**3 visits**	
12 Jan.	'Københavns Fængsler', Vestre Fængsel	Prison section particularly for young persons remanded in custody during investigation of their case	4	0	✓	✓	
31 Jan. to 1 Feb.	'Bakkegården', Nykøbing Sjælland	Two secure sections for children and young persons, particularly persons remanded in non-prison custody during investigation of their case In-house school	7	1			
28 Feb. to 1 Mar.	'Stevnsfortet', Rødvig Stevns	Two secure sections for children and young persons, particularly persons remanded in non-prison custody during investigation of their case In-house school	5	2			
21 to 22 Mar.	'Grenen', Grenå	Two secure sections and a high-security section for children and young persons, particularly persons remanded in non-prison custody during investigation of their case In-house school	6	4	✓		

1) The Ombudsman collaborates with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights (IMR) on monitoring activities. Among other things, they participate in a number of monitoring visits.

2) Number of children and young persons with whom the visiting teams had talks.

3) Number of relatives and personal representatives with whom the visiting teams had talks.

	Selected recommendations etc.[4]
	Visits concluded with recommendations: 7 **Visits concluded without comments: 1** **Not concluded at the time of going to press: 4**
	– Consider preparing written information about the rights and duties of young persons which is linguistically targeted to young persons – Ensure that staff know the special regulations on 15- to 17-year-old inmates – Ensure adequate documentation for decisions to place inmates in a punitive cell – Consider activities for young people on Saturdays *Case opened on the Ombudsman's own initiative about 15- to 17-year-old inmates at Prison and Probation Service institutions. The case was still pending at the time of going to press.*
	– Provide an adequate description of grounds in reports on incidents involving use of force – Endeavour to observe the deadlines for reporting incidents involving use of force – Ensure awareness and knowledge of the procedures for supervision of young persons in seclusion – Ensure that medical assistance is available for children and young persons with mental disorders placed in seclusion
	– Endeavour to observe the deadlines for recording and reporting incidents involving use of force – Ensure forms for reporting incidents involving use of force have been completed adequately – Consider whether staff's access to information about the young persons is in compliance with the Act on Processing of Personal Data
	– Design seclusion room in such a manner that the risk of self-harming behaviour is minimised as far as possible – Carry out self-check of the safety of the seclusion room once a year – Be aware that self-defence is normally only exempt from punishment if it is necessary to prevent a wrongful attack and unreasonable force is not evidently used

4) The table contains selected, abbreviated recommendations. The full recommendations can be found (in Danish only) at www.ombudsmanden.dk, where concluding letters on monitoring visits are published on an ongoing basis. The table also includes information about cases taken up on the Ombudsman's own initiative following monitoring visits.

Continued next page

WHERE DID WE GO IN 2017?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
30 Mar.	'Kolding Arrest'	Local prison particularly for persons remanded in custody during investigation of their case. The monitoring visit concerned conditions for an asylum seeker between 15 and 17 years of age who was remanded in custody.	1	0	✓		
4 Apr.	'Kompasset', Brønderslev	Secure 24-hour residential facility for children and young persons, particularly persons remanded in non-prison custody during investigation of their case. The monitoring visit concerned conditions for a person between 15 and 17 years of age who was serving time.	1	0	✓		
4 to 5 Apr.	'Børnecenter Østrup', Aars	Asylum centre for unaccompanied underage asylum seekers	11	5	✓	✓	
9 to 10 May	'Egely', Nørre Aaby	Three secure sections and a high-security section for children and young persons, particularly persons remanded in non-prison custody during investigation of their case In-house school	11	1	✓		
5 to 6 Sep.	'Sølager', Skibby and Hundested	Three secure sections for children and young persons, particularly persons remanded in non-prison custody during investigation of their case In-house schools	10	4		✓	

	Selected recommendations etc.[4]
	– Arrange for activities with the inmate that involve contact with other persons – Check which language an inmate speaks best and provide an interpreter who speaks the language – Ensure adequate documentation in reports on placements in observation cells – Ensure closer medical supervision of inmates excluded from association with other inmates *Case opened on the Ombudsman's own initiative about 15- to 17-year-old inmates at Prison and Probation Service institutions. The case was still pending at the time of going to press.* *Case opened on the Ombudsman's own initiative about secure 24-hour residential facilities' rejecting young persons who are undergoing age determination. The case was still pending at the time of going to press.*
	Concluded without comments
	– Consider the basis for the house rule that young persons are not allowed to start a relationship with another resident while staying at the centre – and ensure that the content and application of the rule (if upheld) do not exceed what is required in order for the centre to function as intended and meet its objectives – Ensure a continuous, accessible overview of the number of incidents involving use of force and that the incidents are reported to the Immigration Service – Ensure the development plans for the residents are regularly updated and that they contain specific agreements – Ensure that medicines are handled in accordance with applicable regulations
	– Continue endeavours to prevent and reduce the number of incidents involving use of force – Ensure that use of physical force is only followed by seclusion if there is a legal basis for this – Discontinue unlawful use of force and seclusion in person's own room – Tighten up on documentation in reports on incidents involving use of force – Ensure that young persons placed in a seclusion room are allowed to go to the toilet when needed and based on a specific assessment of whether it is safe for the young person and others to allow the young person to leave the seclusion room
	Still pending at the time of going to press

Continued next page

WHERE DID WE GO IN 2017?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
10 and 23 Oct.	'Udrejsecenter Sjælsmark', Hørsholm (**unannounced spontaneous** visits)	Departure centre, particularly for rejected asylum seekers. The monitoring visit focused on children and young persons.	19	27	✓		
12 Oct.	'Ringe Fængsel'	Closed prison for persons serving time. The monitoring visit focused particularly on the youth section.	4	0	✓		
13 Oct.	'Nyborg Fængsel'	Closed prison particularly for persons serving time. The monitoring visit concerned conditions for a person aged 15 to 17 years who was serving time.	1	0	✓		

	Selected recommendations etc.[4]
	The Ombudsman has asked for a statement in the case. The case was still pending at the time of going to press.
	Still pending at the time of going to press
	Still pending at the time of going to press

DISCUSSIONS, ACTIVITIES ETC. IN RELATION TO BOTH CHILDREN AND ADULTS

DISCUSSIONS WITH KEY AUTHORITIES

Dialogue with the relevant authorities – both at the local level in connection with monitoring visits and at central level – plays an important part in the Ombudsman's monitoring activities.

When	What	Subjects (extract)
17 May	Annual meeting with Ministry of Health	Legal authority problems in house rules at psychiatric wards Coercion in connection with somatic treatment of permanently legally incapable persons Guidance about medical re-assessment of forcible restraint when the patient is asleep Recording of immobilisations with restraint belts in connection with stomach tube feeding Monitoring of record-keeping of use of coercion at psychiatric wards The need for written information for children and young persons about their rights
29 May	Annual meeting with Department of Prisons and Probation	Investigation of inmates' complaints about staff members Follow-up on the theme for 2016 in regard to body searches and urine sampling at institutions for adults Healthcare assistance at Prison and Probation Service institutions The need for written information for 15- to 17-year-old inmates about their rights

OTHER ACTIVITIES

- Six meetings with foreign ombudsmen etc. and two meetings with representatives from the other Nordic ombudsmen offices with discussion and exchange of experience.
- Five meetings with national monitoring authorities with discussion and exchange of experiences.
- Together with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights, the Ombudsman held a meeting with representatives of the civil society. The objective of the meeting was to inform the participants about our monitoring activities and to obtain information about their experiences and gain inspiration through joint dialogue.
- As part of the Danish children's ombudsman collaboration, the Ombudsman generally collaborates with the Danish National Council for Children and with Children's Welfare (a Danish organisation offering the Child Helpline, the Children's Chatroom etc.). As part of the collaboration, a dialogue meeting about asylum children was held with relevant interested parties.
- Developing a catalogue of recommendations for monitoring visits to institutions for adults as an operational tool for visiting teams (improvement of our own practice).

OTHER RESULTS

- The National Board of Social Services published the handbook 'Vold og seksuelle overgreb mod børn med handicap – Håndbog om forebyggelse, opsporing og håndtering' ('Violence and sexual abuse against children with disabilities – A handbook on prevention, detection and handling of such abuse'), only available in Danish. The background for this publication was, among other things, the Ombudsman's general recommendation in his thematic report for 2015 to draw up guidelines on how institutions for children with disabilities may prevent sexual abuse and which procedures the institutions should follow in cases of suspected abuse.

SUMMARIES OF SELECTED STATEMENTS – RELATING TO MONITORING ACTIVITIES

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

Summaries are provided below (by ministerial area[1]) of the statements published on cases concluded in 2017 which related to monitoring activities.

G. MINISTRY OF JUSTICE

2017-16. Not adequately substantiated that use of restraint in connection with attempted deportation was necessary for its entire duration

In October 2015, an Ombudsman legal case officer monitored an attempted deportation by the National Police of a man, his wife and their young child. During boarding, the deportation was aborted at the request of airline staff as the man and his wife offered resistance.

The Ombudsman concluded that the deportation report of the police did not meet the requirements on documentation. The Ombudsman found the documentation to be inadequate because the use of restraint by the police officers on the man and the woman during boarding was not adequately described in the deportation report. In addition, the course of events after the deportation had been aborted was inadequately documented as the deportation report contained no information about the factors and assessments on which the police officers had based their decision to keep the man's hands/arms strapped in a restraint belt after the deportation was aborted at about 6 p.m. and until he was returned to the Ellebæk Institution for Detained Asylum Seekers at 9.30 p.m.

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

Finally, the Ombudsman concluded that the police had not adequately substantiated that the use of restraint on the man after the deportation was aborted had been necessary for its entire duration.

2017-18. Significant documentation errors in connection with protracted placement in security cell

Following a monitoring visit to a prison, the Ombudsman initiated an investigation of a case of the prison having kept an inmate in a security cell for more than four days in order to prevent him from harming himself. The inmate had been forcibly restrained to the bed by means of a waist belt, wrist straps, ankle straps and gloves. The prison had reported the case to the Department of Prisons and Probation, which had informed the prison that it had taken note of the report.

Under the Corrections Act, an inmate may be placed in a security cell if, for instance, it is necessary in order to prevent suicide or other self-harm. If necessary, the inmate may also be forcibly restrained to a bed by means of a waist belt, wrist straps, ankle straps and gloves. A guard must be permanently present to supervise an inmate who has been forcibly immobilised, and the guard must note his or her observations at least every fifteen minutes in a special supervision form. If in exceptional cases an inmate remains immobilised for more than 24 hours, the case must immediately be reported to the Department of Prisons and Probation.

During the Ombudsman's investigation of the case, the prison provided significant information which had not previously been available about the inmate's behaviour while he was immobilised. Both the prison and the Department expressed their regrets that the documentation in the case had been inadequate, and the Department acknowledged that it should have asked for supplementary information on receiving the report from the prison.

The Ombudsman agreed that the documentation had been inadequate and that the Department of Prisons and Probation should not have informed the prison on the basis of the information then available that it had taken note of the report.

The Ombudsman was unable to carry out an in-depth investigation of the case but had no grounds for assuming that the inmate had been kept in the security cell for longer than necessary.

2017-33. Significant improvements in Greenland police detention facilities

A visiting team with representatives from the Ombudsman's office and a human rights expert from the Danish Institute for Human Rights made a monitoring visit to the police detention facility at Kulusuk in Greenland in August 2013. The facility is not permanently staffed by police.

The visit revealed, among other things, that persons placed in the facility had no possibility of summoning help from the municipal bailiff ('kommunefoged'), that they were not offered food or drink and that they could not use the toilet unless the municipal bailiff was present. In addition, all persons placed in the facility were stripped to their briefs and searched regardless of whether there was a specific reason for this. Further, the municipal bailiff had the only key to the facility.

Following the visit, the Ombudsman raised some questions with the Ministry of Justice, the National Police and the Chief Constable of Greenland. As a result, the authorities improved the conditions in a number of respects, and new rules on the duties, training and equipment of municipal bailiffs were issued.

One of the improvements was that municipal bailiffs were now required to keep persons placed in detention facilities under continuous supervision. A municipal bailiff was only permitted to leave a person placed in a detention facility in the event of another incident of extreme urgency, such as a shooting incident, arising elsewhere where attending to the incident clearly outweighed the risk and disadvantages of leaving the person alone in the facility.

However, the Ombudsman was still concerned about the safety of persons placed in the five detention facilities in Greenland which were not permanently staffed by police – as persons placed in the facilities would in most cases be unsupervised and unable to summon help in situations where the municipal bailiff temporarily left the facility.

For this reason, the Ombudsman recommended that the authorities consider a number of questions in relation to the safety of persons placed in the five facilities.

Based on the information which the Ombudsman had received about the conditions at the time for persons placed in the detention facility at Kulusuk, he agreed with the authorities that the general conditions for these persons did not contravene the prohibition of torture and other inhuman or degrading treatment under Article 3 of the European Convention on Human Rights.

T. MUNICIPAL AND REGIONAL AUTHORITIES ETC.

2017-9. Significant errors in relation to use of door alarms in municipal residential facility

Following a monitoring visit to a municipal residential facility, the Ombudsman opened three cases concerning the installation of door alarms at the housing units of three residents with impaired mental functioning. The objective of the alarms was to warn staff if the residents, whose behaviour caused problems, left their housing units – thus making it possible to prevent injury to the residents themselves or others.

Under the Social Services Act, the use of door alarms is to be approved by the municipality before alarms are installed. However, the Ombudsman took for his basis that in the three cases, the door alarms had been installed without a decision having been made and thus without the necessary legal basis. The Ombudsman considered this a matter for severe criticism.

The Ombudsman found no grounds for criticising the period of use of the alarms specified by the municipality in its subsequent decisions. However, he found it regrettable that the municipality had not reassessed the need of continuing to use the alarms after no later than eight months, as required by the Executive Order on Forcible Measures and Other Restrictions, in any of the cases.

The Ombudsman also noted that the documentation was inadequate in several respects in all three cases. For this reason, among others, the Ombudsman was unable to reach a final conclusion as to whether the affected residents and their relatives/guardians had been adequately included before the municipality made its decisions.

Further, the Ombudsman considered it very regrettable that the decisions were not communicated in writing to the affected residents and/or their relatives in two of the three cases. In addition, it was an error that incorrect (obsolete) guidance on appeal was given in the same two cases.

The large number of errors made in the three cases caused the Ombudsman to express general concern about the procedures of the municipality. However, he noted at the same time that in the light of these cases, the municipality had initiated various measures of a general nature in order to ensure adherence to the rules of administrative law in future.

2017-13. No authority for secure institutions to wash young residents' clothes to destroy illegal substances

In connection with a monitoring visit to a secure institution, the Ombudsman's visiting team became aware that the institution had an established practice of washing all the young residents' clothes on their arrival. This was done, among other reasons, because it enabled the institution to destroy or reduce the quality of any illegal substances which might be hidden in the clothes.

In a statement on the case, the Ombudsman explained when and in what ways secure institutions are permitted to use forcible measures and other restrictions. In the Ombudsman's opinion there was no authority under the relevant Act or Executive Order for the practice described of requiring the young people to hand in their clothes for washing on arrival. The Ombudsman also stated that it was to be regarded as highly doubtful whether such a restrictive measure could be authorised by the non-statutory legal principle of implied powers (a Danish principle that a public institution may to a certain degree establish such rules and make such decisions as are necessary for the overall functioning of the institution). The Ombudsman gave weight to, among other things, the fact that the legislature had decided when passing the Act on Adult Responsibility for Children and Young Persons in Placement Facilities not to follow a recommendation made by the pre-legislative committee to give secure institutions the right to search children's and young persons' clothes in addition to the right to frisk children and young persons.

However, the Ombudsman was of the opinion that the principle of implied powers did authorise the institution's practice of requiring residents to hand over their outdoor clothes on arrival and its ban on wearing outdoor footwear inside.

The Ombudsman recommended that the institution discontinue as soon as possible its practice of washing residents' clothes on their arrival.

2017-27. No authority for secure institution to check residents' mail

In connection with a monitoring visit to a secure institution, the Ombudsman was informed that the institution checked the mail received by the residents. In addition, the house rules stated that mail was to be opened in the presence of staff.

In a statement on the matter, the Ombudsman examined the legal basis for when authorities are permitted to use measures of this nature. The Ombudsman agreed with the authorities that the Social Services Act did not authorise checks of residents' mail. In addition, the Ombudsman was of the opinion that, contrary to what the authorities had stated, there was not sufficient authority for the regime under the principle of implied powers (a Danish principle that a public institution may to a certain degree establish such rules and make such decisions as are necessary for the overall functioning of the institution). Further, because the regime could not be considered to be sufficiently authorised, the requirement of legality under Article 8 of the European Convention on Human Rights on the right to respect for private and family life, the home and correspondence could not be considered to be met.

Although the Ombudsman was understanding of the views put forward by the authorities on the purpose and basis for the regime of checking the residents' mail, he recommended that the institution discontinue the regime.

The case also involved an issue of the institution's use of a 'seclusion room'. However, as the institution informed the Ombudsman that it no longer had such a room – which had been used for its purpose on one occasion only – the Ombudsman found no cause to comment in detail on this issue.

NEWS – RELATING TO MONITORING ACTIVITIES – PUBLISHED ON THE OMBUDSMAN'S WEBSITE IN 2017

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

4 January

Ombudsman to focus on social psychiatric residential facilities in 2017

In 2017, the Ombudsman's Monitoring Department will have special focus on conditions at the country's social psychiatric residential facilities.

9 January

More openness in relation to monitoring visits

The results of the Ombudsman's monitoring visits will in future be published on the Ombudsman's website. This will be done to enable interested parties to keep updated on which institutions the Ombudsman visits and the outcome of the visits. The information available will include the Ombudsman's final recommendations to the institutions.

In addition, the Ombudsman will publish on his website a new manual for monitoring activities which describes in detail how monitoring visits are carried out.

11 January

Improved conditions for mentally ill inmates of Vestre Fængsel

The participation of mentally ill inmates of the local Copenhagen prison Vestre Fængsel in social activities has increased over the last four years. This is the good news following visits to the prison hospital in 2012, 2013 and 2016 by monitoring teams from the Ombudsman, assisted by medical experts from DIGNITY – Danish Institute Against Torture and human rights experts from the Danish Institute for Human Rights.

12 January

Ombudsman to look into conditions for young people deprived of their liberty

In 2017, staff of the Ombudsman's Children's Division are going to visit a number of institutions which mainly house young people who are serving a sentence or have been remanded in custody. The reason for this is that the theme for this year's monitoring visits by the Children's Division is young people in secure residential facilities and in state and local prisons.

2 February

Danish Immigration Service to follow up on Ombudsman's recommendations to centre for young asylum seekers

During a monitoring visit to Børnecenter Hundstrup, which houses young asylum seekers, the Parliamentary Ombudsman uncovered a variety of problems. The centre is now due to be closed down and the municipality is no longer to be an asylum centre operator. For this reason, among others, the Ombudsman has brought up some of his recommendations to the centre with the Danish Immigration Service.

9 March

Significant improvements in Greenland police detention facilities

The safety of persons placed in Greenland police detention facilities which are not permanently staffed has been significantly improved. However, some aspects of their safety still give cause for concern, the Ombudsman concludes following extensive dialogue with the responsible authorities.

29 March

Municipality made significant errors in relation to use of door alarms in residential facility

A door alarm can be an important safeguard against people with impaired mental functioning leaving the facility in which they live and potentially exposing themselves or others to injury. But a door alarm also constitutes a restriction on the freedom of the individual, and a number of statutory requirements must be met before a municipality installs an alarm. This is emphasised by the Ombudsman, who became aware of significant errors in relation to the use of door alarms in connection with a monitoring visit.

19 April

Rejected asylum seekers at Departure Centre Kærshovedgård treated according to rules

On 31 October 2016, the Ombudsman made a monitoring visit to Departure Centre Kærshovedgård. The visit exclusively concerned the conditions for rejected asylum seekers – not for persons with tolerated residence status or persons sentenced to deportation.

Based on an overall assessment, the monitoring visit gave the Ombudsman no cause to take further action.

16 May

Obligatory washing of young residents' clothes illegal

An institution mainly for young people remanded in custody has consistently washed all the young people's clothes on their arrival, even if the young people have not wanted it. This has been done for hygienic purposes, but also to destroy any euphoriants which may have been hidden in the clothes. However, the legislation does not permit such a measure, the Ombudsman concludes.

17 May

Mentally ill children and young people regularly strapped to beds

It happens regularly that a child or a young person in a psychiatric ward is involuntarily strapped to a bed. This is revealed by a report on children and young people in inpatient psychiatric care just published by the Parliamentary Ombudsman.

18 May

Body searches and urine sampling carried out according to rules

At 32 monitoring visits carried out in 2016, the Ombudsman focused on body-searching and urine sampling.

The Ombudsman's overall conclusion is that the rules are observed with very few exceptions and that the inmates and residents themselves find that body searches and urine sampling are carried out professionally. There is nothing to indicate that body searches and urine sampling are performed for harassment purposes.

21 August

Prisons tighten up on use of security cells

Being placed in a security cell and strapped to a bed is one of the most intrusive actions to which a citizen may be subjected by the state. For this reason, all the required procedures must be followed, the Ombudsman has emphasised in several contexts. The Prison and Probation Service has now taken a number of initiatives to ensure that the rules on placements in security cells are observed.

5 September

Ombudsman raises questions about treatment of 15- to 17-year-old inmates in institutions under the Prison and Probation Service

During a monitoring visit by Ombudsman staff to the local prison in Kolding, a young inmate told the Ombudsman staff that he thought he was 'going insane'. The young inmate had had to spend about 45 days alone in his cell – except for four days in company with another inmate.

...

The monitoring visit to the local prison in Kolding and another monitoring visit to the unit for young offenders of the local Copenhagen prison Vestre Fængsel have caused the Ombudsman to open an investigation of the conditions for 15- to 17-year-old inmates in institutions under the Prison and Probation Service.

6 September

Secure institution not entitled to check residents' mail

When a resident of the secure institution Kofoedsminde receives a letter or a parcel, he or she will be asked to open it in the presence of two staff members. If the resident refuses, the mail will be returned unopened. If he or she consents, contents such as dangerous objects or euphoriants will be confiscated.

The Ombudsman is understanding of the regime of checking the residents' mail, but in his opinion it is not legal. For this reason, the Ombudsman has recommended that Kofoedsminde discontinue the regime.

27 October

Hearing in Parliament to focus on the Access to Public Administration Files Act, the area of immigration, freedom of expression and safety in social care residential facilities

On Wednesday 15 November 2017 at 10 a.m. to 12 noon, Parliament's Legal Affairs Committee will hold its annual hearing about the work of the Parliamentary Ombudsman, at which the Ombudsman and members of his staff will present issues of current interest for questions and discussion.

2 November

Ombudsman raises question about legal basis for placing children of asylum seekers or foreign nationals without legal residence in care against parents' or guardians' wishes

The Ombudsman has raised the question with the Ministry for Children and Social Affairs whether the legal basis for placing children of asylum seekers or of foreign nationals without legal residence in Denmark in care against their parents' or guardians' wishes is adequate.

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FOLKETINGETS OMBUDSMAND

Thematic report 2017

Social psychiatry – security for residents in social residential institutions and in sector transfers

Doc. No. 18/00939-28

1. What has the theme led to?

Social psychiatry – security for residents in social residential institutions and in sector transfers – was chosen as a theme for the monitoring visits which the Ombudsman in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture carried out in 2017 in institutions for adults.

THE PSYCHIATRIC SYSTEM

The psychiatric system can be divided in three branches: **hospital psychiatry** (open, closed and forensic psychiatry wards), **community psychiatry** and **social psychiatry**.

At the hospitals, examination, diagnosing and medicinal treatment are undertaken. In addition to hospital psychiatry, there are local community psychiatric units providing outpatient treatment. The five Regions are responsible for treatment within hospital psychiatry and community psychiatry.

Social psychiatry includes all kinds of support for daily life (besides medical treatment) for residents with mental health disorders – for example social residential institutions, drop-in centres, support person programmes, etc. The municipalities are responsible for necessary programmes being available to the residents. This can be effected by the municipalities making their own programmes available, possibly through a joint effort with other municipalities, Regions or private actors.

As part of the theme, the Ombudsman investigated:

1. Are the security-related conditions for residents in social residential institutions sufficient?
2. Are there sector transfer problems between social residential institutions and the psychiatric sector?

Re 1.

The Ombudsman's overall assessment is that more can and must be done in order to improve resident security and the feeling of safety in social residential

institutions. In recent years, the focus, which has been on improving staff security, has only to a lesser degree rubbed off on resident security.

In most of the social residential institutions which the Ombudsman visited during 2017, there were no guidelines on violence and threats among the residents (anti-violence policy), no systematic record-keeping of violence and threats among residents and therefore also no systematic analyses of violence and threats in order to find causes and patterns. In all institutions visited, the Ombudsman's team have spoken with at least one resident who expressed concern about his or her safety in relation to other residents or outside persons in the social residential institution. In a few institutions, several residents expressed concern.

During the main part of the visits, the Ombudsman's visiting team recommended implementing guidelines on handling violence and threats among residents. See Appendix 1 for an overall view of relevant actions and initiatives on improving resident security in social-psychiatric residential institutions.

Re 2.

The Ombudsman's overall assessment is that the collaboration in sector transfers between the social-psychiatric residential institutions and the psychiatric wards can and must be improved. Problems in sector transfers have in a number of cases meant that residents have not received the optimal treatment.

All the social residential institutions visited reported to having experienced multiple examples of inexpediencies in connection with residents' admission to or discharge from psychiatric wards or as part of the collaboration with wards during residents' hospital stay. For example, some social residential institutions had experienced that a resident was discharged with an hour's notice before arrival to the social residential institution late at night just before the weekend. The social residential institutions found this most problematic.

In order to make sector transfers less problematic, the Ombudsman's visiting team recommended in a number of cases that specific collaboration agreements were made between the social residential institutions and the treatment facility in the psychiatric sector which had the relevant social residential institution in its catchment area. Among other things, the agreements ought to include a description of the conditions affecting admission, hospital stay and discharge.

The result of the themes of the Ombudsman's monitoring visits is described in more detail below, see subheadings 4.1 and 4.2.

The Ombudsman's thematic report is going to be discussed with the Ministry for Children and Social Affairs and the Ministry of Health in order for the ministries to consider how to deal with the identified problems. As part of his future monitoring visits, the Ombudsman is going to follow up on the recommendations given in connection with the investigation of the 2017 theme.

2. Reasons for the choice of theme

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

Between 2012 and 2016, five staff members in social residential institutions lost their lives in consequence of being attacked by mentally ill patients. The media reported intensely on the tragic cases and on several cases of violence towards both staff members and other residents in the social residential institutions. The media also described that 16 cases of rape in three social residential institutions in the Copenhagen area had been reported to the police over a number of years.

From the media coverage, it became evident that staff members in a number of institutions found that they had residents who were too mentally ill to stay in a social residential institution and more correctly ought to have been admitted for treatment at a psychiatric ward. The staff members also stated that the social residential institutions found it problematic that residents were discharged too early and that the social residential institutions – after having had a resident hospitalised – did not get the necessary information from the psychiatric sector about the resident's continued treatment or about what had taken place during the hospitalisation.

According to several media, the psychiatric wards for their part did not recognise the problems outlined.

In recent years, several investigations have been made of the conditions in social-psychiatric residential institutions with the objective to prevent violence in the social residential institutions. Please see for instance "Vold på botilbud og Forsorgshjem" (Violence in social residential facilities and care homes), published in 2016 by the

Central Denmark Region/the National Board of Social Services and written by DEFACTUM; ”Voldsforebyggelse på botilbud og forsorgshjem” (Prevention of violence in social residential facilities and care homes), published in 2017 by the National Board of Social Services and written by the then SFI – The Danish National Centre for Social Research – (now VIVE – The Danish Center for Social Science Research); and ”Nationale retningslinjer for forebyggelse af voldsomme episoder på botilbud samt på boformer for hjemløse” (National guidelines on prevention of violent episodes in social residential facilities and in accommodation facilities for the homeless), published in 2017 by the National Board of Social Services. (All publications in Danish only).

The great focus on violent attacks also resulted in the political conciliation parties earmarking DKK 400 million to the prevention of violence and threats in social residential institutions when negotiating the 2016 agreement on the rate adjustment pool earmarked for disadvantaged groups. Among other things, the pool was allocated to 150 new residential places in the psychiatric sector for long-term treatment of residents with externalising behaviour in social residential institutions. The 150 new places are expected to have been established by the end of 2018.

The primary focus in the public debate has been staff security. Resident security for those who live in social residential institutions has not been a key point in the debate. The reason for the 2017 choice of theme was therefore a concern about whether the social residential institutions in a similar way ensure the safety to which residents are entitled, and whether the collaboration between the social residential institution and the psychiatric sector is sufficient in ensuring necessary treatment for residents in social residential institutions.

Therefore, in connection with his 2017 monitoring visits to institutions for adults, the Ombudsman chose to clarify conditions for residents in social-psychiatric residential institutions by using the two said key questions: whether resident security is sufficient in social residential institutions, and whether there are sector transfer problems between social residential institutions and psychiatric wards.

3. What did the Ombudsman do?

3.1 How was the investigation organised?

The theme was investigated through 13 visits to social-psychiatric residential institutions and seven visits to psychiatric wards. See Appendix 2 for a list of institutions visited.

When choosing the 13 social residential institutions, the Ombudsman emphasised, among other things, that these were institutions subject to sections 107 or 108 of the Social Services Act about temporary and long-term social residential institutions, and that the social residential institution's target group included persons with hospital orders and persons with dual diagnoses (mental health disorder combined with substance abuse). Included were both small and large social-psychiatric residential institutions throughout the country. Eight of the social residential institutions were municipal, three were regional, and two were under private management.

In order to clarify any sector transfer problems between social residential institutions and psychiatric wards, the Ombudsman also visited seven psychiatric hospital wards in 2017 throughout the country, except for the North Denmark Region.

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 people 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 collaboration with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights. DIGNITY and the Institute for Human Rights contribute to the collaboration with medical and human rights expertise. Among other things, this means that personnel with this expertise participate on behalf of the two institutes in the planning and execution of and follow-up on monitoring visits.

3.2 What did the Ombudsman investigate?

In the course of the year's thematic visit, the following conditions were investigated:

- Do the social residential institutions have an anti-violence policy?
- Do the social residential institutions keep records of violence and threats?
- Do the social residential institutions analyse records in order to find causes and patterns to be included in the preventive measures?
- Do the social residential institutions make risk assessments?
- How do the social residential institutions protect residents when they feel unsafe?
- Which information is sent on to the social residential institution by the psychiatric ward after admission of a patient residing in a social residential institution?

- Is there a standard, systematic, cross-functional/cross-sectorial cooperation between the psychiatric ward and the social residential institution?
- Have the psychiatric wards (in recent years) had to turn down residents from social residential institutions for other than medical reasons, for instance for capacity reasons or security reasons?
- Have the psychiatric wards had to discharge patients to social residential institutions too early due to capacity reasons or security reasons?
- Have the psychiatric wards had patients admitted for longer than necessary because there was no room in suitable social residential institutions?

3.3 How were conditions investigated?

Prior to each visit, the Ombudsman asked the institution for information about various conditions, partly about the institution in general, partly about the residents included in the visit.

Among other things, each institution was asked to provide information about the number of incidents of abuse, violence and threats within the last three years among residents, against residents and against staff. Furthermore, each institution was asked for a brief report on, among other things, how the institution prevents, deals with and follows up on specific incidents of violence and threats and – in relation to social residential institutions – a report on how the social residential institution cooperates with the psychiatric sector. See Appendix 3 for an example of an opening letter sent prior to the Ombudsman's visit to one of the social residential institutions visited.

During the monitoring visits, the written information was clarified in more detail for the Ombudsman via talks with management, staff and residents/patients. In total, we have talked with 75 residents, 44 patients and 39 relatives, including guardians, patient advisors, etc. in the course of the year's thematic visits.

4. What did the Ombudsman find?

It is the Ombudsman's overall assessment that more can and must be done in order to improve residents' security and strengthen their feeling of safety. In recent years, the focus, which has been to improve staff security, has only rubbed off on resident security to a lesser degree.

Furthermore, it is the Ombudsman's assessment that, for the benefit of the overall optimal treatment of residents, collaboration agreements should be made between the

social-psychiatric residential institutions and the psychiatric wards which have the institutions in their catchment area. Among other things, the agreements should include a description of the conditions affecting admission, hospital stay and discharge.

4.1 Resident security in social residential institutions

Residents' problems in the social residential institutions visited varied. There were residents with a varying degree of support needs due to, for example, mental health disorders, substance abuse problems or social challenges. For instance, it could be residents with low aggression control or low impulse control and with difficulties interacting with other people. The complex nature of this is described in the aforementioned publication from the National Board of Social Services, "Vold på botilbud og Forsorgshjem" (Violence in social residential facilities and care homes). (In Danish only). The publication says, among other things:

> "Generally, it is a shared starting point that all citizens are mentally vulnerable and have communication difficulties. In addition, more citizens have a tough time when it comes to social relations and physical health. However, it is possible to point out a probable connection between substance abuse and financial difficulties. Thus, it is the citizens, who are substance abusers, who feel they are under pressure and stress because of financial difficulties or the substance abuse environment." (Unauthorised translation).

All the social residential institutions visited had experienced incidents with threatening and violent residents to a greater or lesser extent.

All the social residential institutions visited worked on preventing violence and threats among residents, to a certain extent. For the greater part of the social residential institutions visited, it is therefore an integral part of the pedagogical work to employ, for instance, 'low arousal' or similar pedagogical methods involving conflict inhibition in relation to residents, and that there is zero tolerance in regard to violence and threats. The residents, with whom the Ombudsman's visiting team talked in the social residential institutions visited, generally expressed great satisfaction with the staff in the social residential institutions.

In the social residential institutions visited, the residents interviewed by the visiting team, were asked, among other things, if they felt safe in the institution. In all of the social residential institutions, there was at least one resident who said that he or she could feel unsafe because of some of the other residents in the institution or because

of outside persons. At least 20 out of 75 residents interviewed said that they could feel unsafe. The feeling of being unsafe was more pronounced in some social residential institutions than in others.

For some residents, the feeling of being unsafe was so serious that they basically did not leave their rooms if they were not accompanied by staff. In one institution, at the instigation of the Ombudsman's visiting team, one resident was equipped with an alarm due to the resident's feeling of being unsafe which was based on actual incidents of violence and threats from co-residents.

Management were often not aware of the feeling of being unsafe expressed by residents, and managements agreed with the Ombudsman's visiting team that more had probably been done about staff security than about resident security in the social residential institutions.

Many of the activities initiated for staff over the most recent years can also be implemented advantageously in relation to residents. Among other things, this applies to implementation of anti-violence policies, risk assessments and record-keeping and analyses of the occurrence of violence and threats among residents.

Therefore, it is the Ombudsman's opinion that managements in social residential institutions should increase their focus on resident safety and, to the extent relevant, implement relevant measures.

4.1.1 Anti-violence policy

To a certain extent, all the social residential institutions visited had a written policy on violence and threats *against staff*.

On the other hand, it greatly varied to which extent the social residential institutions had a policy on violence and threats *among residents*. Five social residential institutions did not have a written policy on violence and threats among residents at all. Four social residential institutions had sub-elements of a policy which, however, in the Ombudsman's opinion was not fully adequate, for instance because preventive measures or follow-up with the involved residents had not been decided on. The remaining four social residential institutions had implemented a complete policy on the matter immediately preceding the Ombudsman's visit.

In one of the social residential institutions visited, management reported that there had been an incident a few weeks prior to the visit. A resident had threatened to kill

another resident, chasing him with a butter knife. The incident ended when the first resident smashed the windscreen of a staff member's car. After the incident, management had, among other things, required crisis counselling for the staff members in accordance with the social residential institution's policy on handling violence and threats against staff. By contrast, management could not account for any actions taken in regard to the residents involved.

During the visit, the Ombudsman's visiting team talked with the neighbour of the resident who had been attacking the other resident. The neighbour said that the resident in question often went berserk. The frequent fits of rage made him (the neighbour) anxious, and he wished that the staff would talk with him after the incidents.

In the social residential institution in question, there were no written guidelines on how staff were to follow up in regard to residents who were affected by a violent incident. Established guidelines on follow-up in regard to residents involved could have led to support being provided. The Ombudsman's visiting team recommended the social residential institution to draw up written guidelines on violence and threats against residents.

In seven out of 13 social residential institutions, the Ombudsman's visiting team recommended that the social residential institution draw up a written anti-violence policy or extend an already existing anti-violence policy on violence and threats among residents.

In the Ombudsman's view, an anti-violence policy has to consider, among other things: 1) preventive measures, 2) handling of victim, offender and any other affected fellow residents in connection with a specific incident, 3) follow-up with victim, offender and affected fellow residents and 4) handling of violence and threats of violence from outside persons.

Almost all social residential institutions visited had zero tolerance in regard to violence and threats. Among other things, this means that it was an established policy to report violence and threats to the police. If such an established policy exists, it should be included in the anti-violence policy and be communicated to residents.

4.1.2 Risk assessment

The purpose of risk assessment is to improve the prediction of a resident's externalising behaviour, thereby avoiding the onset and escalation of conflicts. Risk

assessment is an instrument for staff in social residential institutions. There are various instruments for performing risk assessment – and to varying degrees, they include the resident by working with the resident's self-insight and coping capability.

The most widely used kind of risk assessment in the 13 social residential institutions visited was Brøset Violence Checklist (BVC). Accordingly, eight of the 13 social residential institutions used BVC – if required, in combination with other risk assessment methods.

With the BVC method, residents are assessed based on a number of parameters such as confusion, irritability, boisterous behaviour, verbal threatening, physical threatening and attacking objects. Typically, residents are assessed once per shift. The systematic approach ensures that staff constantly relate to residents' condition and initiate steps, if necessary.

In addition to BVC, the social residential institutions used a number of other risk assessment instruments to a lesser degree, for example APG (Aggression Profile and Guideline), the traffic light model, coping charts, workplace assessment at resident level, etc.

The staff members interviewed by the visiting teams said in general that risk assessment is a great instrument which gives an immediate overview of residents' condition and helps prevent violence and threats.

The visits showed that 11 of 13 social residential institutions visited used one or more of the recognised risk assessment instruments.

A common feature of the social residential institutions not using a risk assessment instrument was that they were small, private social residential institutions making it easy for staff to get an overall view of the individual resident. However, one of the two social residential institutions had just, as a trial scheme, implemented systematic use of risk assessment in one of its two wards with the aim of evaluating whether it should be extended to the entire social residential institution.

Therefore, the Ombudsman's visiting team did not find grounds for recommendations regarding this point.

However, the visits also showed that the use of risk assessments may be dilemma-filled. For instance, in one of the social residential institutions visited, staff had seen

that a resident had reacted negatively to being assessed and that the risk assessment had escalated the conflict. It was a small social residential institution where staff were in close contact with residents. So, risk assessment had been abandoned. However, the institution held a daily morning meeting with staff discussing the handling of individual residents and events of the day.

In another social residential institution using BVC, management reported in more general terms that assessments per se could escalate conflicts. The social residential institution sought to counteract this by being very open and by explaining to the resident how and why BVC is used, and why the resident in the specific case had been assessed ('scored') problematic in behaviour, and about the various specific consequences the assessment would cause.

Residents in the social residential institutions visited were not informed of fellow residents' risk assessments. Hence, the social residential institutions were aware that it was a matter of sensitive personal data which legislation does not allow them to pass on to other residents. Furthermore, the social residential institutions found that openness about individual residents' risk level would create unnecessary anxiety among residents. Instead, the risk assessed resident was shielded or otherwise taken special care of in order to protect the other residents as well as the staff.

The Ombudsman agreed with the social residential institutions' evaluations and did not give recommendations regarding this point.

4.1.3 Keeping records of violence and threats

The visits showed that the social residential institutions in general were very careful about keeping records of incidents of violence and threats *in relation to the staff* – among other things, because it may be included in a possible work-related injury case for the staff member in question. In most social residential institutions, records were used systematically to follow the development in the occurrence of violence and threats over time. In some places, the records were also analysed in order to find causes and patterns of the incidents. Among other things, it was investigated if there was a pattern of occurrence in regard to time of day, week or month, location of occurrence of violence and threats, situation (for instance medicine intake or meals) and which staff members were involved.

The result of the analyses were used actively in the prevention of violence and threats.

It was a different picture when it came to records and analyses of violence and threats *among residents*. The visits showed that by far the majority of the social residential institutions kept records of incidents of violence and threats in the individual resident's journal or diary. By contrast, the institutions did not keep systematic records which would have made it possible to monitor the development over time or to make analyses to find causes and patterns, as was the case in most social residential institutions in regard to violence and threats against staff. Therefore, a number of social residential institutions were not able to account for the development of violence and threats among residents in the past three years, and only a few of the social residential institutions had recently started analysing the recorded incidents as part of the preventive measures.

In order for systematic records and analyses hereof to be able to reinforce the prevention of violence and threats, it is a prerequisite that the incidence is at a certain level. Often, it is therefore not as relevant to keep such systematic records and analyses in small social residential institutions as it is in large ones with many incidents.

Based on considerations regarding possible reinforcements in the preventive work, the Ombudsman recommended that five of the 13 social residential institutions visited in future keep systematic records of violence and threats among residents and analyse the records in order to reinforce the preventive work in, for instance, identifying if it is specific situations that trigger a resident's externalising behaviour.

4.1.4 Unreported figures

In connection with the issue of keeping records of violence and threats among residents, managements in social residential institutions often mentioned that inevitably there had to be a rather large number of unreported figures. This is due to the fact that violence and threats among residents often occur in, for instance, residents' flats or in other places where the social residential institutions' staff do not become aware of the incident.

The managements' statements were confirmed when the Ombudsman's visiting team during talks with residents became aware of conflicts and incidents which management did not know about.

For instance, in one social residential institution, a female resident said that a male resident had forced his way into her flat and beaten her because she owed him money. The woman was frightened of the male resident and wanted an alarm. In

another social residential institution, the visiting team learned that a resident for a longer period of time had been exploited by a fellow resident. Therefore, the exploited resident had been admitted to the psychiatric sector with the objective of being offered another social residential institution. During the visiting team's talks with residents in the same social residential institution, a third resident said that he – after the exploited resident had been admitted – had become the latest victim of exploitation from the same fellow resident.

With consent from the residents, their information was passed on to managements who said they would solve the problems immediately.

To get an insight into the scale of the unreported figures, the Ombudsman's visiting team mentioned in a number of the large social residential institutions that it might be a good idea in anonymous satisfaction surveys among residents to incorporate questions, among other things, on whether residents had been exposed to violence and threats and on whether residents would tell staff about this if that was the case. In one of the social residential institutions visited, an annual life quality measurement was already established, including questions which clarified residents' feeling of safety in the social residential institution.

4.1.5 Handling of medication

The majority of residents in the social residential institutions visited were on medication for mental health disorders.

If medication is not taken as directed by the prescribing physician, the risk increases of the resident becoming more mentally ill, thereby increasing the risk of the resident's behaviour becoming externalising. Most residents in social residential institutions get help from the institutions with the administration of their medication. It is therefore important that the social residential institutions have regular and safe procedures ensuring correct handling of medication.

In 12 of 13 visits to social residential institutions, DIGNITY's physicians participated in order to assess these procedures, among other things.

In three cases, the Ombudsman's visiting team gave recommendations based on DIGNITY's assessments. Among other things, recommendations were given on:

- increased focus on correct handling of medication so as to be in accordance with the Danish Patient Safety Authority's guidelines

- ensurance that the staff in charge of the handling of medication have the proper qualifications, and
- a systematic follow-up on unintentional incidents and adjustment of working procedures when the follow-up showed a need for adjustment.

4.1.6 Other preventive measures

In addition to the issues which the Ombudsman's visiting team have given recommendations on, many other conditions play a part when it comes to security and the feeling of safety in a social residential institution.

On the basis of discussions with the social residential institutions' managements, the Ombudsman's visiting team have made a note of the following conditions of special importance:

- *Consistency with the target group:* Management have to make sure there is consistency between the individual resident and the social residential institutions' target group in the preadmission evaluation because the risk of conflicts increases if residents, who are not compatible with the social residential institution's target group, are admitted to the social residential institution.
- *Physical environment:* For instance, sharing kitchen and bath may cause conflicts.
- *Staff-related conditions:* High staff turnover may increase the risk of conflicts among residents.
- *Substitute staff:* The same substitute staff should be used so that they know the individual institution's procedures and views on pedagogy and the prevention of violence and threats. Substitute staff must always be on duty with a permanent staff member who is familiar with these procedures and views.

In a number of social residential institutions, managements drew the Ombudsman's visiting team's attention to the specific issue of residents with dual diagnoses (mental health disorder combined with substance abuse).

The issue was that these residents were caught in a cross field between the psychiatric sector, which cannot treat active substance abusers, and the municipal substance abuse treatment programme, which cannot treat residents with severe mental health disorders because it is allegedly a condition for treatment that residents have normal cognitive levels. Some social residential institutions had attempted to solve the problem by employing their own substance abuse treatment therapist. The

Ombudsman assesses that it is a systemic problem and is therefore going to present this point to the ministries responsible.

4.2 Sector transfer problems

Besides the 13 visits in social residential institutions, the Ombudsman has made seven visits to psychiatric wards across four Regions in the course of 2017.

The purpose of visiting social residential institutions as well as psychiatric wards was to investigate whether managements in the two types of institution had the same view on the collaboration between the institutions, and to identify potential improvement in the collaboration.

It is the Ombudsman's assessment that there are problems in the collaboration between the social-psychiatric residential institutions and the psychiatric treatment wards in regard to ensuring the overall optimal treatment of residents in social residential institutions.

See examples below of treatment issues seen from the social residential institutions' as well as from the psychiatric sector's perspectives.

However, the entire extent of sector transfer problems is not known since no systematic record-keeping in this area exists – for example records that it has not been possible to have a resident hospitalised. Neither social-psychiatric residential institutions nor psychiatric wards kept such records. In a number of social residential institutions, the Ombudsman has recommended that sector transfer problems are recorded systematically just like the Ombudsman in a number of cases has recommended the establishing of proper formalised collaboration agreements between social residential institutions/municipalities and psychiatric wards/Regions.

4.2.1 Perspective of social residential institutions

In the social residential institutions, the collaboration with the psychiatric wards was viewed rather differently. Some of the social residential institutions were very dissatisfied whereas one social residential institution found the collaboration entirely satisfactory. The other social residential institutions had had problems in connection with sector transfers to a varying degree.

The sector transfer problems experienced by the social residential institutions revolved especially around the difficulty of getting residents admitted, and that residents, who

had been hospitalised, were discharged way too early. All social residential institutions could exemplify this to a varying extent.

In this way, the majority of the social residential institutions reported of examples of residents who – in the social residential institution's opinion – ought to have been admitted but had been rejected or discharged again after a few hours in hospital. There were also a number of examples of residents having been discharged without prior notice to the social residential institution or at problematic hours, for example 3:30 am on a Saturday. Furthermore, some social residential institutions could give examples of residents' whose medication had been altered without the social residential institution being informed hereof.

However, none of the social residential institutions kept systematic records of the number or nature of problematic experiences in connection with their residents' admission, hospital stay and discharge. Therefore, the social residential institutions could not account in more detail for the extent of the problems or whether it was a case of negative development.

The social residential institutions also reported of some residents, who the social residential institutions would characterise as 'revolving door patients', seeing that they were admitted several times a year. Similarly, no systematic record-keeping or analyses were made in these cases. At four visits in larger social residential institutions, the Ombudsman's visiting team recommended that such record-keeping was implemented.

Eight social residential institutions said they had had problems getting residents sectioned. Among other things, this was because emergency doctors or general practitioners were scared of residents with externalising behaviour and therefore reluctant to talk with the resident, or because the physicians allegedly did not feel competent in the decision about sectioning. This meant that residents could not be sectioned even when the social residential institution viewed this as the correct action to take. Again, the social residential institutions did not keep systematic records of this problematic issue either.

Anyhow, the collaboration with the local psychiatric treatment facility about the individual resident was in general described as satisfactory by the social residential institutions once the resident had been admitted. Still, the cases where the collaboration failed put a heavy strain on the resident, the staff and the other residents in the social residential institutions and involved a great risk for all. The collaboration

was, when it was well-functioning in relation to the resident admitted, driven by good relations between one or more experienced staff member(s) and similar staff in the local psychiatric treatment facility. However, the relation-borne collaboration was often of a fluctuating character because the turnover of consultant psychiatrists in some wards was frequent, according to the social residential institutions, whereby the developed relationship disappeared.

Five of the social residential institutions visited had implemented – or were in the process of implementing – local collaboration agreements. Accordingly, to an increasing extent, the social residential institutions saw that a proper collaboration agreement with the local psychiatric treatment facility about admission, hospital stay and discharge can be very useful in improving the collaboration about residents living in social residential institutions. There was also an increasing focus on the fact that knowledge of the working conditions in the psychiatric sector – and, the other way around, the psychiatric sector's knowledge of the working conditions in the social residential institutions – is useful for obtaining the best collaboration possible.

Among other things, collaboration agreements can include agreements on job swaps, visits to one another's institutions in order to encourage mutual understanding of possibilities and limitations, video conferences about residents/patients at set intervals, description of channels of communication with permanent staff members from both institutions, description of the most suitable admission and discharge and agreements on who is in charge of which tasks regarding the resident during hospitalisation.

In six social residential institutions, the Ombudsman's visiting team recommended the implementation of such agreements. In social residential institutions where the municipality as the owner of the social residential institution was represented, the Ombudsman's visiting team recommended that more general agreements between the social psychiatric sector and the local psychiatric treatment facility were implemented also at central level between municipality and Region.

4.2.2 Perspective of psychiatric wards

In the psychiatric wards visited, it was generally stated that residents from social residential institutions are never rejected, nor are they discharged too early to the social residential institution.

In some of the wards visited, there was extended collaboration with a few of the catchment area's social residential institutions. Most often, the collaboration was not

formalised in a collaboration agreement but depended on relations between staff members of the social residential institution in question and the psychiatric wards, also mentioned above under sub-heading 4.2.1. The psychiatric wards were positive about entering into collaboration agreements with social residential institutions in the catchment area, and, in relevant cases, the Ombudsman's visiting team recommended entering into such agreements.

The psychiatric wards did not keep systematic records of which patients resided in social residential institutions. Therefore, it was not possible to investigate whether this group of residents holds more residents, who can be categorised as 'revolving door patients', than the group of residents living at home. However, it was the general perception that 'revolving door patients' more often were living in their own home. Meanwhile, in the psychiatric sector's view, they should not be living in their own home – instead, they should have the option of staying in a social residential institution.

According to some of the psychiatric wards, this is because the municipalities have difficulties ensuring a sufficient number of suitable social residential institutions for such residents who besides mental health disorders suffer from a variety of other problems, for instance substance abuse or mental handicaps.

Some of the psychiatric wards also pointed out that they experienced problems in regard to the fact:

- that certain municipalities have closed down crisis placements in social residential institutions so that patients, ready for discharge but not able to get by in their own home, were hospitalised longer than necessary
- that a number of patients, viewed by the psychiatric sector as not being able to get by in their own homes, stay too long in the psychiatric sector because the municipalities provide support in the home instead of offering placement in a social residential institution
- that certain social residential institutions in the summer holiday period admit residents who cannot be taken care of in their social residential institutions due to lower staffing levels during the summer holiday period.

It was not possible to put a figure on the scope of the problems mentioned since no systematic records of the problems were kept. Here, the Ombudsman's visiting team pointed out that the recommended collaboration agreement could also be designed in a way so as to include such problems, cf. above about collaboration agreements.

The Ombudsman's thematic report will be sent to the Ministry for Children and Social Affairs and the Ministry of Health, relevant parliamentary committees, relevant boards, agencies and regional social supervision authorities in order to ensure a continued focus on the problematic issues.

Copenhagen, 13 June 2018

Jørgen Steen Sørensen

Appendix 1

Relevant actions and initiatives

During the year's monitoring visits to social-psychiatric residential institutions and psychiatric wards, the Ombudsman has given a number of different recommendations.

The specific recommendations, which the Ombudsman has given during the individual visit, can be seen in the concluding letter to the institution, which is published on www.ombudsmanden.dk (in Danish only).

On the basis of this year's monotoring visits, the Ombudsman has compiled a list of actions and initiatives which can help increase resident safety in social-psychiatric residential institutions and improve the collaboration between social residential institutions and the psychiatric sector. See the list of actions and initiatives below.

Security:

- that social-psychiatric residential institutions draw up written guidelines on violence and threats against fellow residents, including, among other things, guidelines on 1) preventive measures, 2) handling of victim and offender and any other fellow residents not directly involved, 3) follow-up with the groups mentioned, 4) handling of violence and threats of violence from outside persons

- that social-psychiatric residential institutions keep systematic records of the occurrence of violence and threats among residents and analyse data with a preventive aim, etc.

- that social-psychiatric residential institutions apply risk assessment in their daily work and implement relevant actions if a resident poses a risk of externalising behaviour

- that social-psychiatric residential institutions have a clear policy on police reports which is known to staff

- that social-psychiatric residential institutions are aware of any unreported figures in the records of occurrence of violence and threats among residents

- that social-psychiatric residential institutions focus on correct handling of residents' medication in order to avoid medication errors, among other things

- that social-psychiatric residential institutions continuously check whether residents' need for support corresponds with the social-psychiatric residential institution's target group

- that social-psychiatric residential institutions make sure that the physical environment to the widest extent possible is designed so as to lessen the risk of conflicts. For instance, sharing kitchen and bath may cause conflicts.

- that social-psychiatric residential institutions focus on ensuring staff stability as high staff turnover may increase the risk of conflicts among residents. To the extent that the use of substitute staff is needed, it should be the same substitute staff who know the individual social residential institution's procedures and views on pedagogy and the prevention of violence and threats. Substitute staff should always be on duty with a permanent staff member who is familiar with these procedures and views.

- that social-psychiatric residential institutions attend to the continued skills development of staff, for instance via seminars on conflict management or violence prevention and follow-up seminars.

Sector transfers:

- that social-psychiatric residential institutions keep systematic records of incidents experienced in regard to admission, hospital stay and discharge from the psychiatric sector.

- that collaboration agreements are made between the social-psychiatric residential institutions/municipality and the treatment facility in the psychiatric sector/Region regarding residents' admission, hospital stay and discharge from psychiatric wards. Among other things, collaboration agreements can include agreements on job swaps, visits to one another's institutions in order to encourage mutual understanding of possibilities and limitations, video conferences about residents/patients at set intervals, description of channels of communication with permanent staff members from both institutions, description of the most suitable admission and discharge and agreements on who is in charge of which tasks regarding the resident during hospitalisation.

Appendix 2

List of institutions visited

When	Name and location	With whom did we speak		Who participated[1]	
		Users[2]	Relatives[3]	DIGNITY	IMR
	Social residential institutions				
8/3	'Botilbuddet Røde Mellemvej', Copenhagen	12	2	✓	✓
9/3 and 24/3	'Botilbuddet Robert Jacobsens Vej', Bagsværd	7	1	✓	✓
15/3	'Østergården', Rude	5	5	✓	✓
28/3	'Botilbuddet Skovsbovej', Svendborg	8	4	✓	
3/4	'Lindegårdshusene', Roskilde (unannounced visit)	8	0	✓	✓
26/4	'Botilbuddet Teglgårdshuset', Middelfart	2	2	✓	✓
3/5	'Åkandehuset', Højby	4	4	✓	✓
18/5	'Bostedet Visborggaard', Hadsund	10	4	✓	
28/6	'Bostedet Vendelbo', Vrå (unannounced visit)	5	0	✓	
29/6	'Bostedet Brovst'	4	3	✓	
7/9	'Tangkær', Ørsted	6	0	✓	
12/10	'Tagabo', Copenhagen	2	0	✓	✓
25/10	'Gartnervænget', Sakskøbing	2	0		✓

[1] The Ombudsman collaborates with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights (IMR). Among other things, they participate in a number of monitoring activities.
[2] Number of residents and patients with whom the visiting teams talked.
[3] Number of relatives, guardians, social security guardians and patient advisors with whom the visiting teams talked.

	Psychiatric sector				
16/1	'Psykiatrisk Center København', Bispebjerg	5	1		✓
18/1	'Psykiatrisk Center København', Rigshospitalet	4	1		
9/2-10/2	'Psykiatrien Slagelse', forensic psychiatric ward	15	2		
27/4	'Psykiatrisk Afdeling Svendborg'	3	2	✓	
8/5	'Aarhus Universitetshospital', Risskov (unannounced visit)	4	0	✓	
7/6	'Regionspsykiatrien Vest', Herning	9	4	✓	
26/9	'Psykiatrisk Afdeling Odense'	4	4	✓	
	In total, 20 institutions	119	39		

Recommendations given during the individual monitoring visits can be seen in the concluding letters to the institutions which are published on www.ombudsmanden.dk.

Appendix 3

Monitoring visit to Social Residential Institution A

As agreed by telephone with principal B, the visit to Social Residential Institution A is scheduled for **Thursday XXXX 2017**. The visit begins at 9:00 am.

There are no specific conditions in A leading to the Ombudsman's wish to visit the social residential institution. The monitoring visit is conducted as part of the Ombudsman's general monitoring activities and as part of the Ombudsman's OPCAT activities, cf. below about reasons for and purpose of the visit.

As the theme for 2017, the Ombudsman has chosen to look into conditions for persons residing in social-psychiatric residential institutions. In this connection, the Ombudsman is especially investigating the following issues:

- Are the security-related conditions for residents in social residential institutions sufficient?
- Are there sector transfer problems between social residential institutions and the psychiatric sector?

To a great extent, the desired information relates to these matters:

However, the visit will also focus on, among other things, use of physical force, interventions towards and restrictions on citizens, relations between residents and in regard to staff (including violence and threats), residents' access for occupational activities, and health-related conditions.

The visiting team consists of Deputy Head of Department, Consultant Erik Dorph Sørensen and Legal Case Officer Katrine R. de Lasson from the Ombudsman institution and Director General, Physician Karin Verland from DIGNITY – Danish Institute Against Torture.

With a copy of this letter, I have informed Region C and Regional Social Supervision Authority D about the visit. I have asked the Region and the Regional Social Supervision Authority to inform me of whether the Region and the Regional Social Supervision Authority wish to participate in the visit.

For your information, I enclose a copy of my letters to the Region and the Regional Social Supervision Authority.

Information in advance

For my preparation for the visit, I ask that I receive various types of information on **Tuesday XXXX 2017** at the latest:

1. Latest supervision report from the regional social supervision authority
2. Supervision report from The Danish Patient Safety Authority, if any
3. House rules
4. A list of the social residential institution's residents with information about age, gender, language, functional capacity, ethnic background, grounds for placement and time of placement, and residents with special needs

   Furthermore, please inform us of the following:

   - Does the resident have a psychiatric diagnosis?
   - Does the resident have a hospital order/court order?
   - Is the resident a substance abuser?
   - Does the resident have a record of violence or threats in the social residential institution?
   - How many times has the resident been admitted to a psychiatric ward within the last three years (or since moving into the social residential institution if the resident has lived in the institution for less than three years?)
5. The social residential institution's in-house guidelines on use of physical force
6. A list with the number of occurrences of physical force within the last three years
7. Feedback, if any, from the regional social supervision authorities and the residency municipality/Region on reports of use of physical force.
8. The social residential institution's guidelines on the handling of cases of threats, violence and abuse (anti-violence policy)
9. A list with the number of occurrences of abuse, violence and threats within the last three years (among residents, against residents and against staff), stating the number of cases where the threatening or violent resident has had a psychiatric diagnosis
10. In how many cases management, staff or residents, respectively, have reported a resident to the police
11. The social residential institution's local directions on medication handling
12. A list of the institution's staffing (number of staff, staff groups, their training and their seniority) including information on staffing days, nights and on weekends
13. Information on sickness absence (listed in percentage per staff group within the latest three years)

14. The use of substitute staff (when and to which extent are substitute staff used and which qualifications do the substitute staff have)
15. The latest minutes from meeting with the resident council
16. The latest minutes from meeting with relatives
17. Information on number of suicides and suicide attempts within the latest three years
18. The latest section 141 action plan among residents covered by one or more of the categories under subsection 4.1 above
19. The social residential institution's own similar (action) plans for the three residents
20. The latest report from the Danish Working Environment Authority on the mental work environment
21. Procedures/guidelines on risk assessment of residents moving in as well as on a regular basis (for example by the use of BVC or SOAS-R (Staff Observation Aggression Scale))
22. Information to residents moving in regarding the social residential institution's approach to violence and threats, including any reactions towards the resident in case of the resident behaving in a threatening or violent manner
23. Number of cases within the latest three years where the social residential institution has deemed admission to a psychiatric ward necessary but where admission has not taken place after all
24. Copy of material, cf. item k) below – (for instance rehabilitation programmes, discharge agreements (section 13 a of the Danish Mental Health Act), coordination plans (section 13 b of the Danish Mental Health Act), etc.) which the social residential institution has been given by the psychiatric sector in connection with the latest discharge of a resident from the psychiatric sector to the social residential institution

Furthermore, I ask for a report on the following:

a) How the social residential institution prevents residents ending up in inhuman or degrading situations
b) Which significant problematic incidents the social residential institution has experienced within the latest year
c) Which main professional challenges (except financial) the social residential institution faces in 2017
d) How the residents' access to health services is organised
e) How the residents' access to occupation, education and leisure time is organised
f) If there has been a development within the latest three years in the occurrence of violence and threats, management is asked to give an account of the possible causes behind this development
g) How is violence and threats prevented in the social residential institution?
h) How does the social residential institution handle residents who behave in a threatening or violent manner?
i) What is the follow-up on specific incidents of violence and threats? Including for example the practice of record-keeping, reporting to the police etc.

j) How does the collaboration with the psychiatric sector work? Including the social residential institution's residents' access to a psychiatric ward and the issue of discharge of patients from a psychiatric ward to the social residential institution. Preferably with information on the conditions that are viewed as challenging by the social residential institution.
k) Which information is received/accessible when a resident is received from the psychiatric sector (for instance rehabilitation programmes, discharge agreements (section 13 a of the Danish Mental Health Act), coordination plans (section 13 b of the Danish Mental Health), etc.?
l) How does the social residential institution find the municipalities' supervision of individual residents?
   - How is the structure?
   - How often do the municipal supervision authorities visit?
   - Are there differences from municipality to municipality?

When sending the material, I ask that it is numbered in accordance with the points above. As always, any confidential information can be sent to me via ordinary post but you are also welcome to send it to me via secure e-mail to post@ombudsmanden.dk.

Programme for the visit

Primarily, the visit is carried out through talks with the social residential institution's management, residents and staff. Talks with residents will include talks with residents who have signed up in advance as well as talks with a number of selected residents whom the visiting team on the day of the visit have asked if they wish to have a talk. Talks with staff can be carried out as group talks if that is desirable by the staff.

Furthermore, the visiting team would like to talk with representatives for the residents and relatives/guardians. Therefore – if possible – I ask that the social residential institution make arrangements for such talks. Such talks can also be carried out by telephone during the visit.

In general, the talks will revolve around the 2017 theme as described above.

I ask that the talks are carried out at times that fit into the social residential institution's daily programme. At present, it is not possible to say exactly how long the individual talks are going to take but in principle it is a question of fairly brief talks of 10-15 minutes' duration. The visiting team have the option of splitting into two groups, making it possible to carry out two talks at a time.

The visit also includes a presentation tour of the social residential institution's physical environment.

The visiting team want the visit to open and close with meetings with the social residential institution's management. The visiting team expect that the opening meeting is going to last approx. 2 hours and that the closing meeting is going to last approx. 1 hour. Prior to the closing meeting, the visiting team have a pre-meeting of approx. 45 minutes' duration.

At present, it is not possible to say when the visit is going to end on the day. Among other things, this depends on the number of persons asking for a talk.

On this background, I ask that the social residential institution send me a suggestion for a programme for the visit, including the talks mentioned. The social residential institution is welcome to contact me for further clarification of the planning of the visit. I ask that I receive the programme and a list of the residents, relatives and staff who wish to talk with us on **Monday XXXX 2017 at the latest.**

Notice

I ask that the social residential institution put up the enclosed notice about the visit together with the information sheet on the Parliamentary Ombudsman, or inform residents, relatives and staff representatives about this in any way the social residential institution finds most suitable. I enclose the folder "Information about your rights". In the folder, residents can read more about the rules for the Ombudsman's activities and about how to complain to the Ombudsman. The folder is also available on the Ombudsman's website, as download also, and in certain other languages. If you wish to download the folder in other languages, you initially have to select the desired language in the top right hand corner on the website by clicking the small globe icon. I ask that the social residential institution hand out a folder to the residents who wish to have a talk and to any other persons who might wish to get the folder.

Background and purpose of the visit

The Parliamentary Ombudsman will regularly carry out monitoring visits, among other things to institutions where people are or can be deprived of their liberty. Partly, the monitoring visits are carried out as part of the Ombudsman's general monitoring

activities pursuant to section 18 of the Ombudsman Act, cf. Consolidating Act No. 349 of 22 March 2013, and partly in accordance with the Optional Protocol to the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, cf. Order No. 38 of 27 October 2009. The Ombudsman's work in order to prevent degrading treatment, etc. in accordance with the protocol is carried out in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

Pursuant to section 21, the Ombudsman shall in connection with his activities, including his monitoring visits, assess whether persons or authorities falling within his jurisdiction act in contravention of 'existing legislation or otherwise commit errors or derelictions in the discharge of their duties'. In connection with the Ombudsman's monitoring activity, section 18(ii) also applies. Pursuant to this provision, the Ombudsman can, in addition to assessments pursuant to section 21, assess 'matters concerning the organisation and operation of an institution or authority and matters concerning the treatment of and activities for users of the institution or authority on the basis of universal human and humanitarian considerations'.

If A has any questions in connection with the monitoring visit, you are welcome to contact the undersigned on telephone number + 45 33 13 25 12.

Yours sincerely,
For the Ombudsman

Erik Dorph Sørensen
Souschef

Erik Dorph Sørensen
Deputy Head of Department

Appendix 4

Themes for monitoring activities

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

The choice of theme is particularly dependent on which areas are in need of an extra monitoring initiative. The Ombudsman will often choose a narrow theme, such as for instance the Prison and Probation Service's use of security cells. Other times, the Ombudsman will choose broad themes, such as for instance institutions for the elderly and substance abuse treatment.

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 the relevant 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 take place in institutions where the themes are relevant.

Thematic reports

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

The themes are specifically 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 threats among residents.

General recommendations are based on the Ombudsman's experience of the area in question. Usually, they will also have been given as specific recommendations to particular institutions during the year's 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 website, www.ombudsmanden.dk. In addition, the Ombudsman will send the reports to the relevant authorities so that the authorities can include the reports in their deliberations regarding the various sectors.

FOLKETINGETS OMBUDSMAND

Report

Thematic report 2017 Young people in secure care residential institutions and local and state prisons

Contents

1. Introduction

Young people in secure care residential institutions, local prisons and state prisons was the theme of the monitoring visits which the Ombudsman carried out in 2017 in the child sector in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

Young people in secure care residential institutions, local prisons and state prisons

There are 8 secure care residential institutions in Denmark.

Children and young people can be placed in secure care residential institutions for criminal, welfare and immigration law reasons.

By a secure care residential institution is meant a residential institution with one or more units where it is permitted to keep outer doors and windows permanently locked.

Secure care residential institutions may also have one or more special secure care units.

Special secure care units are aimed at children and young people whose previous violent or psychologically deviant behaviour has made staying in a secure care residential institution unsafe.

Special secure care units must be physically separate from the general secure care residential institutions.

To the widest possible extent, 15-17-year-old remand prisoners are placed in the secure care residential institutions.

Unless key regards for law enforcement make it necessary, 15-17-year-old offenders are not placed in a local or state prison.

1.1. What has the theme led to?

The monitoring visits gave the Ombudsman the impression that the institutions generally deliver an important and valuable contribution, partly to help

and support the young people during the placement, and partly to give the young people a foundation on which they can build their future and further development after the placement has ended.

In addition, the visits gave the Ombudsman an impression of what is important to the young people. A number of statements from the young people about this have been written into the report.

The visits revealed that the recording and reporting of the use of force can be improved in the secure care residential institutions. On that basis, the Ombudsman gave a general recommendation that the secure care residential institutions endeavour to keep the deadlines for recording and reporting the use of force and that the institutions reports the use of force adequately.

The Ombudsman has discussed the follow-up on these general recommendations with the central authorities. In addition, the Ombudsman will follow up on the recommendations during his future monitoring visits.

The secure care residential institutions must summon a physician when placing children and young persons with mental disorders in solitary confinement so that the physician can decide whether it is necessary to admit the child or young person to a psychiatric ward for children and young people. The Ombudsman has discussed with the Ministry for Children and Social Affairs whether there is a need to clarify the expression “mental disorders” in the Executive Order on Adult Responsibility. In addition, the Ombudsman has discussed the institutions’ challenges regarding the medical preparedness with the Ministry.

The Ombudsman has also discussed the issue of access to toilet visits during solitary confinement with the Ministry for Children and Social Affairs, including whether it is necessary to provide guidance on how the secure care residential institutions are to respond to the issue.

The Ombudsman has furthermore discussed the lack of action plans for children and young people placed in care with the Ministry for Children and Social Affairs, and the Ombudsman has discussed with the Ministry whether it is necessary to improve the standard form for reporting the use of force in as far as involvement of the young person is concerned.

The Ministry for Children and Social Affairs will consider the issues discussed with the Ombudsman.

The secure care residential institutions' in-house schools have various challenges in connection with teaching the young people, for instance with providing the full curriculum, exemption from subjects and holding exams. The Ombudsman will take up these issues with the Ministry of Education.

On the basis of monitoring visits to local and state prisons, the Ombudsman has raised a number of questions on his own initiative with the Department of the Prison and Probation Service and the Ministry of Justice regarding conditions for 15-17-year-old inmates.

To that, the Ministry of Justice has informed the Ombudsman that the Ministry is considering the implementation of rules to ensure that inmates of compulsory school age serving a prison sentence in institutions under the Prison and Probation Service be offered education which match that of the Danish Folkeskole (primary and lower secondary school).

The Ministry of Justice will also consider whether there is a need to change the legislation for education of 15-17-year-old remand prisoners.

In addition, the Department of the Prison and Probation Service has informed the Ombudsman of new measures which are intended to ensure uniform compliance with the special rules that apply to 15-17-year-old inmates. The Department has also stated that work is progressing on a professional standard with guidelines for case processing in connection with the imprisonment of 15-17-year-olds.

Information from the monitoring visits to local and state prisons has in addition given the Ombudsman grounds for discussing with the Department of the Prison and Probation Service whether there is a need for centrally drafted written material with information about the young people's rights and duties in a language targeted at young people. The Department will consider this question.

On the basis of his observations of where and under what conditions 15-17-year-olds can be placed in local and state prisons, the Ombudsman has discussed this issue with the Department of the Prison and Probation Service.

Among other things, the Ombudsman has also raised an issue with the Department of the Prison and Probation Service and the Ministry of Justice about the rules for partly placement of 15-17-year-olds in certain closed prisons, and partly 15-17-year-olds' association with adult inmates in certain closed prisons.

The Ombudsman has sent this report to all responsible authorities in the sector: The Ministry for Children and Social Affairs, the National Board of Social Services, the social supervision authorities, the Ministry of Education, the Ministry of Justice, the Department of the Prison and Probation Service and the Ministry of Health. The purpose is to make the authorities aware of the report so that it can enter into their deliberations regarding the sector. The report has also been sent to those secure care residential institutions, local and state prisons which the Ombudsman visited as part of the theme. In addition, the Ombudsman has informed Parliament's Legal Affairs Committee, Domestic, Social Affairs and Children's Committee, Education Committee and Supervisory Board in accordance with Section 71 of the Danish Constitutional Act, as well as Danish Regions and Local Government Denmark.

Read more about the Ombudsman's work involving themes in the Appendix at the back of this report.

1.2. Background for the choice of theme

The Ombudsman's monitoring activities are especially aimed at the most vulnerable members of society. Characteristic of these vulnerable citizens are, among other things, that they have very few resources and that their rights can easily come under pressure. This can also apply to young people in secure care residential institutions, and in local and state prisons.

In addition, the Ombudsman prioritises visits to institutions with particularly strict regimes. Secure care residential institutions, local prisons and state prisons have particularly strict regimes compared to other institutions in the child sector.

With this theme, the Ombudsman wanted an increased insight into conditions for young people in secure care residential institutions and in local and state prisons, and to examine these conditions in more detail.

In relation to the secure care residential institutions it was central to the Ombudsman to gain a more detailed impression of how the Act on Adult Responsibility – which came into force on 1 January 2017 – is used in regard to the young people. The Ombudsman also wanted to have a look at the education available to the young people in the in-house schools at the secure care residential institutions.

Special rules apply to the 15-17-year-olds who are placed in the local and state prisons under the Prison and Probation Service – among others, the Executive Order on the Treatment of 15-17-year-olds placed in Institutions under the Prison and Probation Service, with accompanying guidelines. It was important to the Ombudsman during the visits to local and state prisons

to gain an insight into the way in which these rules are used in relation to the young people.

The theme took its starting point in some of the Ombudsman's general focus areas during his monitoring visits. For instance, the Ombudsman has a general focus on solitary confinement, on physical use of force and on education. The Ombudsman also has a general focus on the service users' relations, for instance the relationship between the young people placed in care and the staff at the institution, including the provision of information to the young people about their rights.

In addition, another of the theme's starting points was the 2015 report from the National Council for Children, "I was actually a good boy once – young people recount their experience of being deprived of their liberty" (in Danish only). The 2015 report from the Institute for Human Rights, "Children – status 2015-2016", was also included in the basis for the theme.

1.3. What did the Ombudsman do?

The Ombudsman carried out 10 monitoring visits with the aim of clarifying and examining the theme of young people in secure care residential institutions and in local and state prisons.

The theme followed these lines:

- solitary confinement and physical use of force
- education
- the young peoples' relations (rights, youth composition, and inclusion and personal development)

The Ombudsman examined the theme in the following way:

- The Ombudsman visited 6 secure residential institutions. One visit concerned conditions for a 15-17-year-old person serving a sentence, as the purpose of the visit was an in-depth examination of the young person's individual conditions. The 5 other visits went to a total of 12 secure care units, 2 special secure care units and 6 in-house schools.

- The Ombudsman visited 2 local prisons, especially for prisoners on remand while their case is being investigated. One of the visits concerned a local prison unit for young people. The other visit concerned conditions for a 15-17-year-old remanded asylum seeker where the purpose of the visit was an in-depth examination of the young person's conditions.

- In addition, the Ombudsman visited 2 closed prisons (especially) for persons serving a sentence. One of the visits concerned a young offenders' unit in particular, while the other visit concerned conditions for a 15-17-

year-old person serving a sentence whose conditions the Ombudsman examined with particular thoroughness.

- As a starting point, the Ombudsman asked for the following, among other things, from the secure care residential institutions:

    - guidelines for the use of force and information on how the young people and custodial parents are informed about their rights in relation to the use of force and other interventions in the right to self-determination, including channels of complaint
    - copy of each unit's 2 most recent reports in 2016 and 2017 of placing young persons in solitary confinement. If the institution did not have such reports, the Ombudsman asked to have each unit's 2 most recent reports on the use of force
    - list of the municipal action plans received by the institution and copies of the 3 most recent action plans
    - information on which of the young people attended school, including the type of curriculum offered
    - written material targeted at the young people and informing them of their rights.

- In connection with the visits to local and state prisons, the Ombudsman generally asked for information on among other things:

    - forcible and voluntary exclusions from association with others
    - placements in disciplinary cell
    - copy of a special treatment programme for inmates, cf. Executive Order on the Treatment of 15-17-year-olds placed in Institutions under the Prison and Probation Service
    - educational provision, including available curriculum
    - written material targeted at the young people, informing them of their rights
    - inmates' association with other inmates.

- In the week leading up to the monitoring visits the Ombudsman sent a personal letter to each individual young person, informing him or her about the visit and the opportunity to have a talk with the visiting team. A flyer which the Ombudsman enclosed with the letter described what the visiting team would like to talk with the young person about. The aim of this approach was to access as many young people as possible, as they are a significant and important source of information for the Ombudsman. The flyer, which is available in Danish, English and Arabic, is annexed to this report.
- The 8 secure residential institutions in Denmark had 123 places in 2016. This appears from Danish Regions' annual statistics for the secure care

residential institutions in 2016. The young people placed in the secure care residential institutions thus made up a very small part of the just under 12,000 children and young people who according to figures from Statistics Denmark – www.statistikbanken.dk – were placed in care in 2016. In 2016, the average number of young people under the age of 18 in local and state prison was 13.8 (this includes prison, arrest, remand and pursuant to the Aliens Act). These figures appear from the Statistics 2016 of the Prison and Probation Service. Significantly fewer young people are thus placed in local and state prisons than in the secure care residential institutions. The young people whom the Ombudsman visited therefore constituted a small but especially vulnerable group.

By far the majority of the young people whom the Ombudsman met during his visits were young males but the Ombudsman also encountered young females. Most young people in the *secure care residential institutions* were placed there in surrogate custody – meaning that the placement was a substitute for remand in custody. During some of the visits, the Ombudsman also met young people who had been placed at the institution for welfare reasons. The placements were typically of a short duration. One of the secure care residential institutions stated that the average was 3-month placements. In the *local prisons*, the Ombudsman met (particularly) remanded young people while in the *state prisons* he met persons serving a sentence.

The young people whom the Ombudsman met were most often between 15 and 17 years of age but the Ombudsman also encountered young people outside this age group. In addition, during the visits the Ombudsman encountered (unaccompanied) underage foreign nationals with a background as asylum seekers.

– The visiting teams had talks with a total of 50 young people during the monitoring visits. The team also had talks with parents, staff (including teachers) and management. The talks were particularly about solitary confinement, physical use of force, education and the young peoples' relations, but they were also about for instance health-related matters.

The monitoring visits were carried out as part of the Ombudsman's general monitoring activities in accordance with the Ombudsman Act and as part of the Ombudsman's work to prevent that people who are or who can be deprived of their liberty are exposed to for instance inhuman or degrading treatment, cf. the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The Ombudsman's work of preventing degrading treatment, etc., pursuant to the Protocol is carried out in collaboration with DIGNITY – Danish Institute

Against Torture – and the Danish Institute for Human Rights. DIGNITY and the Institute for Human Rights contribute to the collaboration with medical and human rights expertise. This means, among other things, that staff with expertise in these areas participate on behalf of the two institutes in the planning, execution and follow-up regarding monitoring visits.

The Ombudsman has a special responsibility for protecting the rights of children according to the UN Convention on the Rights of the Child, among other things. The Ombudsman's Special Advisor on Children's Issues participates in all visits to the child sector.

1.4. What did the Ombudsman find?

Based on the completed visits, the Ombudsman found, among other things, as follows:

- Young people are frequently placed in solitary confinement, and the handling of solitary confinement can be improved in several places
- The recording and/or reporting of use of force can generally be improved in the secure residential institutions
- In some places a connection can be seen between staff's approach with the young people and the use of force
- The in-house schools at the secure care residential institutions face various challenges in connection with teaching the young people, for instance with teaching the full curriculum, exemption from education and setting exams.
- In many instances, the secure care residential institutions do not receive an action plan for the individual young person.
- There are a number of challenges connected with conditions for 15-17-year-old inmates in the Prison and Probation Service institutions, for instance staff's knowledge of the rules pertaining to this sort of inmate, regulation of education for inmates of compulsory school age, placement and regulation of association in certain closed prisons and preparation of treatment programmes
- Information to the young people about their rights can be improved in local and state prisons.

1.5. What was characteristic of good work with the young people?

The visits left the Ombudsman with the impression that the institutions generally made important and valuable efforts, partly to help and support the young people during the placement, and partly to give the young people a foundation on which they could build their future and their continued development after the placement.

In addition, the visits gave the Ombudsman an impression of what was important to the young people.

What was generally important regarding the work with young people, was the staff's approach. Many of the young people indicated how important it was that the staff treated them well and with respect, were able to stand their anger and frustration, and spoke to them properly.

"[The institution] is five-star.
The staff are nice and speak to you nicely.
They treat you well."
Boy, 17 years

In [the institution] you are given a chance,
and you are shown respect."
Boy, 16 years

Part of being treated with respect was also that staff dared to trust the young people. One institution, for instance, trusted a young person to show members of a supervisory body round the premises.

"[The institution] was better because they [the staff] trusted you
if you yourself showed trust."
Boy, 16 years

Talks with young people showed that good treatment from the staff was not contrary to having clearly defined limits in the institution.

It was important to the young people to have staff who showed them interest and with whom they could speak in confidence.

"I am comfortable with two teachers
whom I can confide in."
Girl, 13 years

"The staff show attentiveness and care."
Boy, 19 years

For some young people with another ethnic or religious background it was important that staff did not use irony or jokes which could be misunderstood. It was also important that considerations regarding religious diet was taken into account.

The young people put emphasis on individual allowances being made in school.

"It is a really good school. You are taught alone. You learn more here than at an ordinary school."
Boy, 17 years

"The school is good. I have previously lived on the streets and still have problems concentrating. I am taught 8-10 minutes at a time, and I can feel that I am improving. I have a good teacher."
Boy, 17 years

The Ombudsman received generally positive comments from the young people about the institutions and their efforts to help the young people. However, a number of young people also mentioned matters where they were specifically dissatisfied, for instance with the lack of activities. In addition, several young people complained for instance about the way staff talked to them, such as in a patronising way. To the relevant extent, the Ombudsman passed on such information to the institution's management and discussed it with management.

2. Secure care residential institutions

2.1. Solitary confinement

In all actions concerning children, the best interests of the child shall be the primary consideration. This appears from the UN Convention on the Rights of the Child.

According to the same Convention, no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. A corresponding prohibition appears from the European Convention on Human Rights.

In addition, according to the Convention on the Rights of the Child, any child deprived of liberty shall be treated humanely and with respect for the natural dignity of man and in a way that shows consideration for age-related needs.

By solitary confinement in a secure care residential institution or a special secure care unit is understood isolation in a locked room for shorter or longer periods of time. This is set out in the legislation on adult responsibility.

The Ombudsman obtained information about the use of solitary confinement during the monitoring visits to secure care residential institutions.

All the visited institutions had solitary confinement rooms, except one.

The solitary confinement rooms were often used every year but there were institutions where this was not the case. Generally, solitary confinement was used rarely – except for one institution where there were many instances of solitary confinement in relation to particularly one specific young person.

The leader of a secure care residential institution or an special secure care unit can decide to place a young person in a special solitary confinement room when there is an imminent danger of the child or young person harming him- or herself or other people.

The Ombudsman recommended to one institution to ensure that use of force would only be followed by solitary confinement if an individual assessment gave grounds for it.

2.2. Duration of solitary confinement

Solitary confinement must be as brief as possible, and it must not last longer than 2 hours in a secure care unit and 4 hours in a special secure care unit. This appears from the Act on Adult Responsibility.

There was a general focus on these time limits on the duration of the solitary confinement.

During a visit, the Ombudsman was informed that a young person had been placed in solitary confinement in a secure care unit for just under 4 hours (2 x 1 hour and 50 minutes, without the young person being allowed out of the solitary confinement room). In the institution's assessment, exceeding the 2-hour time limit was an absolutely necessary act of self-defence.

The Ombudsman recommended that the institution be aware that according to the Criminal Code, self-defence can normally only be exempt from prosecution if it is necessary in order to withstand or deflect an unlawful attack and if it does not exceed that which is justifiable.

Another institution did not to a satisfactory degree document the duration of the solitary confinement. In 2 cases of solitary confinement, for instance, it appeared that the young person was in a solitary confinement room for "about 2 hours".

The Ombudsman recommended that the institution tighten the documentation in its reports on the use of force, etc., including documentation regarding duration.

2.3. Design of solitary confinement rooms

Solitary confinement must only take place in rooms that are especially designed for that purpose. This appears from the Executive Order on Adult Responsibility.

The Ombudsman saw several solitary confinement rooms during his visits. In connection with the visits, the Ombudsman tested among other things the working of the alarm button with which the child or young person in solitary confinement could call staff. The Ombudsman also examined whether safety measures were in order so that it would not be possible for the child or young person to self-harm, including (attempting to) commit suicide. There was focus on whether the child or young person in solitary confinement was shielded from view so that for instance other children or young people could not look into the solitary confinement room while it was in use.

The Ombudsman recommended to some institutions that they designed their solitary confinement rooms in such a way so as to minimise the risk of self-harming behaviour as much as possible. The Ombudsman recommended to one institution to carry out an in-house control of the safety of its solitary confinement room once a year.

2.4. Supervision during solitary confinement

There must be continuous supervision of a child or young person placed in solitary confinement. This appears from the Executive Order on Adult Responsibility. The purpose is to ensure that the child or young person does not self-harm. It must be possible for the child or young person to call staff during the whole period of solitary confinement.

The Ombudsman recommended some institutions to ensure that staff was aware and cognizant of the procedures for supervision of the young people placed in solitary confinement – and, in one case, also with regard to how the alarm button worked.

2.5. Medical preparedness in connection with solitary confinement

When children or young persons with mental disorders are placed in solitary confinement, the institution's attending psychiatric specialist consultant must be called in or – if this is not possible – a medical general practitioner. The physician must be called in immediate connection with the decision of solitary confinement. The physician must regularly consider whether it is necessary to hospitalise the child or young person at a psychiatric ward for children and young people.

The Ombudsman recommended to some institutions that they ensure such medical preparedness in the institution.

In that context, the Ombudsman was informed that there could be some challenges with regard to the medical preparedness. One institution, for instance, explained that it did not have attending psychiatrist who could be called in, and that the institution could call the emergency services doctor but that there was often a long response time. Another institution remarked that the solitary confinement had very likely ended by the time the emergency services doctor got there. One institution with a good contact to a psychiatric ward stated that it was not possible to have a psychiatrist out regularly.

According to the Executive Order on Adult Responsibility, a physician only has to be called in when children and young people with mental disorders are placed in solitary confinement.

In connection with the visits, it was discussed how the expression “mental disorders” in the Executive Order on Adult Responsibility should be interpreted. The guide on adult responsibility does not contain any more detailed contributions to the interpretation.

On that basis, the Ombudsman has discussed with the Ministry of Children and Social Affairs whether there is a need for a more precise interpretation of the expression “mental disorders”. In addition, the Ombudsman has discussed with the Ministry the institutions’ challenges with the medical preparedness.

2.6. Toilet visits during solitary confinement

The issue of access to toilet visits during solitary confinement was discussed in the course of some of the monitoring visits.

One institution had guidelines on how to handle the issue. It appeared from the guidelines that the young person should be conducted back to his or her own room to use his or her own toilet if a visit to the toilet was deemed absolutely necessary and expedient. Afterwards, the situation would have to be assessed with regard to whether or not there was still a statutory basis for the solitary confinement. A slop pail could be used it was not deemed expedient for security reasons to conduct the young person back to his or her own toilet.

The institution provided the Ombudsman with a report of a solitary confinement where the young person had been given a slop pail to use in the solitary confinement room. There was a corner in the solitary confinement room where it was possible to use the slop pail without being watched.

In the course of a monitoring visit to another institution, the young people said in talks with the visiting team that they did not have access to toilet visits during solitary confinement and that staff did not react when the young people

called them. The institution stated that some young people used the call button as a means of provocation towards staff, and that it did not make sense to take the young people out to pee when they were in solitary confinement. Besides, the young people could pee down a grate in the solitary confinement room. If the young person was taken out of the solitary confinement room, the institution ended the solitary confinement.

The Ombudsman recommended that the institution ensure that young people placed in solitary confinement had access to toilet visits according to need and according to a concrete assessment of whether or not it was safe for the young person or others to let the young person come out of the solitary confinement room.

More detailed rules on the access to toilet visits during solitary confinement are not seen to have been established.

The Ombudsman discussed the issue of access to toilet visits during solitary confinement with the Ministry for Children and Social Affairs, including the possible need to give guidance on how the secure social residential institutions should respond to the issue in practice.

2.7. Other measures which may feel like solitary confinement

All the institutions visited used measures which were not called solitary confinement but which may feel like solitary confinement.

The social supervision authority can give a secure care residential institution and a special secure care unit permission to lock the rooms at night for reasons of order and safety. The child or young person must be able to contact staff during the time when the room is locked up. According to the Adult Responsibility Act, the locking of rooms at night does not constitute solitary confinement.

All the visited institutions have permission to lock the rooms at night.

After a monitoring visit, the Ombudsman received a report of a case of solitary confinement. The young person was first placed in a solitary confinement room but was subsequently conducted to his/her own room and locked in, due to lack of space. It appeared from the report that the staff were aware that it was unlawful to lock the young person in his/her own room but the situation did not leave them with any other option.

The Ombudsman recommended that the institution as quickly as possible put an end to unlawful solitary confinement in the young person’s own room.

Prior to another monitoring visit, the Ombudsman received a report of a case of solitary confinement where the staff had chosen to lock the young person in his/her own room before placement in the solitary confinement room. As management had discussed the episode with the staff, the Ombudsman took no steps in that connection.

Several institutions used varying forms of exclusion from association with other young people. Some institutions used time-out where the young person was sent to his/her own room for a period of time, for instance for up to 3 hours. Measures were also used – shielding or segregation where the young person was for instance wholly or partially excluded from association with the other young people for a period of time. In addition, the Ombudsman was told that a young person was allowed to sit in his/her room if he/she did not wish to attend school or participate in activities.

To a relevant extent, the Ombudsman discussed the use of exclusion from association with others with the institutions.

2.8. Recording and reporting use of force

Pursuant to the Executive Order on Adult Responsibility, the manager of a placement facility must record an incident involving the use of force on a reporting form. It is a legal requirement that the recording be made within 24 hours. This is first and foremost for the sake of the legal rights of the child or young person but also for the sake of the staff involved.

After the use of force has been recorded, the placement facility manager must without any unreasonable delay send a copy of the reporting form to the municipality which has placed the child or young person at the facility. By unreasonable delay is meant that the forms must be sent as quickly as possible within 24 hours, once the recording is completed. The manager must therefore send the report on the day it is completed.

It was generally a challenge for the institutions to keep the deadlines, for instance if the use of force took place during the weekend and the manager or the deputy manager who were to send the report were not on duty.

The Ombudsman recommended to most of the institutions to endeavour to keep the deadlines for recording and reporting the use of force. The background for the use of the word “endeavour” in the recommendation was that the Ombudsman on the face of it appreciated that the deadlines could be difficult to keep in some situations.

The Ombudsman has discussed the institutions’ challenge with keeping the deadlines with the Ministry for Children and Social Affairs.

The institutions must record and report the use of force in the standard form provided by the Ministry for Children and Social Affairs. The purpose is to make the process flexible henceforth and to support a uniform practice.

The Ombudsman gave several recommendations regarding improvement of the documentation for the use of force. The Ombudsman thus recommended that one institution write a satisfactory reason in reports on the use of force. Another institution was recommended to ensure that the reporting forms on the use of force was completed satisfactorily. The Ombudsman also gave a recommendation to an institution to tighten the documentation in the report on the use of force, including documentation on the type, necessity and duration of the intervention.

On that basis, the Ombudsman generally recommends that the secure care residential institutions report the use of force satisfactorily.

The child or young person who has been subject to the use of force must be informed of the recording in the reporting form. In addition, the child or young person must be given the opportunity to make a statement and to add his or her own account to the recording.

The Ombudsman recommended to some institutions that they consider noting in the forms on the use of force whether the young person had been offered to give his or her account of the use of force but did not wish to do so.

On that basis, the Ombudsman has discussed with the Ministry for Children and Social Affairs whether there is a need for improvement of the standard form for reporting the use of force, in as far as the inclusion of the young person is concerned.

2.9. Staff's approach to the young people and to the use of force

Some institutions saw a decline in the use of force, while others experienced a rise.

One institution explained a former drop in the use of force with low occupancy and many staff members. In addition, staff had become better at communicating and at de-escalating conflicts. At present, the institution had many incidences with the use of force and it was difficult for staff to reach some of the young people pedagogically. Some young people had therefore been moved within the institution and one young person had been moved to another institution.

Another institution explained its decline in the use of force by staff becoming better at prevention and also by a change in the type of young people it was now receiving. It was also mentioned that the low incidence of the use of

force was due to a good relationship effort and because staff were given courses in de-escalation of conflicts.

During a visit, the visiting team noticed that the institution could also continue its work with standardising staff's approach to the young people as part of the institution's efforts to prevent and reduce the use of force.

The institution was recommended to continue its efforts to prevent and reduce the number of times that force was used.

2.10. Education in the in-house schools

According to the UN Convention on the Rights of the Child, children are entitled to education.

All the secure care residential institutions visited by the Ombudsman had an in-house school for the young people placed in care.

An in-house school is established according to agreement between the institution and the municipality in which the institution is located. The local municipality supervises the education. The supervision shall ensure that the teaching lives up to the requirements set out in the Act on Primary and Lower Secondary Education (the "Folkeskole Act").

The curriculum and student plan of an in-house school must comprise the full range of subjects of a municipal primary and lower-secondary school ("Folkeskole").

With the parents' consent, a pupil in an in-house school can be exempted from lessons in a subject (however, not Danish or maths) if the pupil has unusually great difficulties with the subject. The school principal makes the decision to exempt the pupil on the basis of a pedagogical-psychological assessment. The pupil must have alternative classes instead of the subject in question.

The in-house schools had various challenges in connection with teaching the young people. This was among other things because the young people were often placed there for a short time.

It was a challenge to teach the young people in the full range of subjects of the Folkeskole.

Several in-house schools primarily taught Danish, maths and English but it was also possible to be taught other subjects. Several institutions stated that they were able to cover the full range of subjects of the Folkeskole. There were, however, generally problems with covering physics and chemistry, for

instance because the school did not have the facilities needed for the experimental part of the curriculum.

The institutions managed the problem of lessons in physics and chemistry in a variety of ways. One institution had 'a rolling physics lab' – a rolling table which made it possible for the institution to provide half of the physics syllabus (both theory and practice). Another institution carried out some of the experimental part of lessons in physics and chemistry in a kitchen – "kitchen chemistry".

The Ombudsman received information that many young people were in shock in the initial phase of the placement and therefore often not receptive to teaching. In addition, many young people had very little and often very bad experiences with school. Besides this, the Ombudsman was informed that the young people often faced great challenges with regard to motivation. In several places, the young people most often received one-to-one tuition.

There were variations in the extent to which the schools were aware of the rules on exemption from lessons in specific subjects.

Some institutions stated that no pupils were exempt from lessons. One institution was taking active steps to ensure that the rules on exemption from lessons were observed. Another institution said that it could be difficult to procure information about a possible decision on exemption from lessons that had already been made. A third institution stated that many young people came from special schools where they were already exempted from lessons following involvement of PPR (Pedagogical Psychological Counselling). The placement's short duration meant that it would not make sense for the institution to involve the PPR about an exemption.

The Ombudsman recommended to an institution that it finished its work of ensuring that the rules on exemption from lessons were observed.

Some schools wished that they could hold the Folkeskole's school-leaving examinations continuously. Holding examinations continuously would allow for the conditions of the short-term placements. The wish was based on the fact that the young people were only placed for a short period of time and not always during examination time, that the school-leaving examination was important when the young people moved on in life, and that the school was open year round. One institution felt that 4 annual examination periods would be satisfactory, and the institution also wished that there would not be too great a time lag between the oral and the written examinations.

One school enrolled a number of pupils for examination to ensure that the places were there if the school was going to receive young people due for examination. Some institutions stated that the young people could take their examination at the institution.

The Ombudsman will take up these in-house school conditions with the Ministry of Education.

2.11. Action plans

Generally, the municipality shall draw up an action plan before a child or young person is placed in care. The municipality shall – at the time of the placement – give relevant parts of the action plan to the institution.

Prior to most monitoring visits, the Ombudsman received information on which children and young people had an action plan.

The information showed that many children and young people placed in secure care residential institutions lacked action plans.

In the course of some of the visits the Ombudsman received information that the institution contacted the municipality if they did not receive the action plan for a young person. If no action plan was forthcoming, the institution would itself draw up for instance goals for its performance and inform the municipality.

On the basis of monitoring visits to residential institutions in 2014-2016, the Ombudsman raised 26 cases regarding action plans of which 20 resulted in criticism. Consequently, in May 2017 the Ombudsman asked the Ministry for Children and Social Affairs whether the result gave the Ministry cause to take any steps. The Ministry informed the Ombudsman that several initiatives had been launched to ensure action plans for children placed in care.

The Ombudsman has discussed the lack of action plans for children and young people placed in secure care residential institutions with the Ministry for Children and Social Affairs.

2.12. The composition of the young people

In particular, according to the UN Convention on the Rights of the Child, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so.

A number of institutions experienced challenges with regard to young people with an asylum background who have been placed in care. One institution explained that many of these young people caused fear and uneasiness around them, among other things because most of them were in reality over 18

years. Their behaviour also reflected the fact that they had been through traumatic events and it was difficult to motivate them pedagogically and to sanction their undesirable behaviour – among other things because they had no perspective to their life. Some institutions said that young people from an asylum background were often troubled with for instance substance abuse and self-harm. One institution handled the difficulty with this group of young people presumed to be over 18 years by – as a condition for taking them in – demanding that they had undergone an age assessment.

The Ombudsman has raised a case regarding the rejection of young people by two secure care residential institutions due to a lack of age assessment.

Most of the young people have been placed in a secure care residential institution for reasons pursuant to criminal law but some young people have also been placed there for welfare reasons.

It was the experience of one of the visited institutions that the young people placed there for welfare reasons had many of the same problems as those placed there for reasons pertaining to criminal law, but that the former were generally weaker. The welfare-placed persons at the institution had access to Facebook which could be a problem. The institution tried to motivate the welfare-placed persons to hand over their mobile phone voluntarily and use the telephone at the unit instead.

The welfare-placed young people at another institution had almost the same conditions as the young people in surrogate custody – they did not have access to the Internet and were not allowed to have mobile phones. However, dependent on their resources the welfare-placed young people could go outside the institution. The welfare-placed young people risked creating a network for themselves at the institution that was not appropriate for them, for instance by becoming part of a criminal environment.

A third institution said that there was not a great deal of difference between the young people placed in surrogate custody and the young people placed in care for welfare reasons.

Some institutions could occasionally see a young person first placed for welfare reasons and then coming back in surrogate custody. One institution did not think it mattered that the welfare-placed young people associated with the young people placed according to criminal law.

Generally, the institutions seemed to be of the opinion that the young people placed for welfare reasons often had the same problems as those placed according to criminal law. And it was these problems which meant that the welfare-placed young people at times subsequently ended up in crime and not

necessarily because they had been in contact with young people placed according to criminal law.

2.13. Access to personal data

Most of the secure care residential institutions visited by the Ombudsman wrote information about the young people into their records system. It could be about for instance medical information or indictments.

In a number of institutions, all staff had access to the information. In one institution, however, the staff could not read what the psychologist wrote in his/her special "room", and in another institution the psychiatrist had his/her own records system.

In one institution the staff at the individual units only had access to information about their own residents. However, the school had access to information about all the residents.

A staff member is only allowed to access personal data for reasoned and necessary reasons.

The Ombudsman recommended to most institutions that they consider, in cooperation with the Region, whether the access of staff to information in the records system about the young people complied with the Act on Processing of Personal Data then in force (now the Danish legislation on Data Protection).

3. Local and state prisons under the Prison and Probation Service

3.1. Solitary confinement

3.1.1. The best interests of the child shall be a primary consideration in all actions concerning the child. This appears from the UN Convention on the Rights of the Child.

According to the same Convention, no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. A corresponding prohibition appears from the European Convention on Human Rights.

In addition, any child deprived of liberty shall according to the UN convention on the Rights of the Child be treated with humanity and respect for the inherent dignity of the human person and in a manner which takes into account the needs of his or her age.

According to the Administration of Justice Act, young people under the age of 18 can be remanded in solitary confinement.

In addition, according to the Sentence Enforcement Act remand prisoners and inmates serving a sentence can be excluded from association with other inmates. This can be for instance if it is necessary in order to prevent escape, criminal activity or violent behaviour, to carry out measures necessary for security reasons or for prevention of contagion, or because the inmate exhibits offensive or frequent and repeated inadmissible behaviour which is clearly incompatible with continued association with other inmates. An inmate can be temporarily excluded from association while the question of exclusion is being considered.

Pursuant to the Sentence Enforcement Act, an inmate can also be sanctioned to placement in a disciplinary cell as a disciplinary punishment. A disciplinary cell can be used for instance for non-return after leave, for refusal to give a urine sample, for smuggling in or possession of weapons and other items dangerous to people, for violence and threats against fellow inmates, staff or other persons in the institution, for gross vandalism, or for attempts at the above. An inmate who has been sanctioned to placement in a disciplinary cell is placed in for instance a special unit or own room. During the placement, the inmate is excluded from association with others in the institution.

3.1.2. Young people under the age of 18 are rarely *remanded in solitary confinement* – there were two instances in 2016 and the most recent case before 2016 was in 2010.

In connection with a monitoring visit, the Ombudsman received information about *exclusion from association* of 15-17-year-old inmates. The information caused the Ombudsman to ask the Department of the Prison and Probation Service to inform him, among other things, whether there was a focus on reducing the use of exclusion from association of 15-17-year-old inmates.

The Department of the Prison and Probation Service confirmed that there was such a focus, among other things by the Department reviewing all cases where an exclusion from association had lasted 14 days or more.

In addition, the Department provided the Ombudsman with information on the use of exclusion from association of 15-17-year-olds in 2015, 2016 and parts of 2017.

On that basis, the Ombudsman retrieved information about 2 exclusions of 24 days in 2016. After reviewing the information and on the basis of an overall assessment, the Ombudsman decided not to take further action in the 2 cases.

The Department of the Prison and Probation Service is also focused on restricting the use of *disciplinary cells* for 15-17-year-old inmates.

In connection with a monitoring visit the Ombudsman received information about 2 specific cases involving the use of a disciplinary cell.

On the basis of a review of the cases, the Ombudsman recommended that management ensure sufficient documentation for a concrete assessment that it was imperative to impose the sanction of disciplinary cell, and that it had not been sufficient to impose it as conditional sanction.

In other instances, young people can also have *alone time* in their cell.

In a young offenders unit in a local prison, there were for instance no activities for young people on Saturdays. The monitoring visit caused the Ombudsman to recommend management to consider whether it was possible to arrange activities for the young people on Saturdays despite the institution's limitations with regard to resources and structural facilities.

The regional office stated that for resource reasons such activities were not available at present, and that the institution had chosen to prioritise afternoon activities on three weekdays instead of on Saturdays. In future, in periods when 3-4 young people were placed in the young offenders unit, the institution would organise afternoon activities on Saturdays for the young people. However, it remained uncertain whether such activities would be organised, as there were not in practice 3-4 young people in the young offenders unit. Besides the daily exercise outside, it was also possible to visit each other's cells unsupervised. The Ombudsman decided to take no further action in the matter.

The Ombudsman visited a 15-17-year-old asylum seeker remanded in a local prison. The young person had to be alone in a cell for about 45 days – apart from 4 days when there was another inmate to associate with. The young person was the only underage person in the local prison, and there were no other inmates with whom the young person could associate.

The Ombudsman recommended that management organise activities which involved contact with other persons for the inmate. In addition, the Ombudsman recommended a closer health supervision for inmates who were excluded from association, no matter what the reason for the exclusion was.

3.2. Education

According to the UN Convention on the Rights of the Child, children have a right to education.

15-17-year-olds of compulsory school age must be provided with education with a view to finishing the Folkeskole leaving examination (9th grade) if the academic ability is present. Special education in Danish and arithmetic/maths should be offered in order to rectify any deficiencies in such basic subjects. This appears from the guidelines on the treatment of 15-17-year-olds who are placed in institutions under the Prison and Probation Service.

Based on information from a monitoring visit to a young offenders unit in a local prison, the Ombudsman asked the Department of the Prison and Probation Service for information about the rules regulating the education provided for inmates of compulsory school age, including whether there are for instance rules on mandated hours of education, range of subjects, special needs education, exemption from education, supervision of education and access to complaint corresponding to the rules of the Folkeskole. The Ombudsman asked the Ministry of Justice to respond to the Department's reply.

The Ministry of Justice informed the Ombudsman that the Ministry plans to implement detailed rules in order to ensure that persons of compulsory school age who are serving sentences in Prison and Probation Service institutions are offered an education which measure up to the education provided by the Folkeskole. The rules will be prepared with the participation of the Ministry of Education. The Ombudsman asked to be informed of the coming rules.

With regard to those remanded in custody, the Ministry of Justice informed the Ombudsman that it will involve considerable challenges to implement an appropriate education programme which fulfil the requirements of the Folkeskole Act. The number of 15-to-17-year-old remand prisoners in the institutions of the Prison and Probation Service is limited, and they are typically placed in the institutions for a non-determined time period of shorter duration. The Ministry will therefore consider whether there is a need to change the legislation with a view to departing from the rules of the Folkeskole. The Ombudsman asked to be informed of the result of the Ministry's deliberations.

3.3. Placement of 15-17-year-olds

According to the UN Convention on the Rights of the Child, any child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person and in a manner which takes into account the needs of his or her age (cf. 3.1. above). In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so.

In 2017, the Prison and Probation Service had 3 units for young offenders – the Young offenders unit at Copenhagen Prisons, Vestre Prison, which is a

local prison, the Young offenders unit at the open prison in Jyderup, and the Young offenders unit at the closed prison Ringe. Young people can also be placed in other local prisons than Copenhagen Prisons, just as young people can be placed in other open prisons than Jyderup Prison. Placement in closed institutions takes place at Ringe Prison (from 1 June 2018 at the closed Young offenders unit of Søbygård Prison), at Herstedvester Prison or in a local prison (Copenhagen Prisons). This is implied in the Executive Order on the Treatment of 15-17-year-olds placed in Institutions under the Prison and Probation Service. Please see under 1.2.

If it is not possible to allow a 15-17-year-old inmate access to association with other young people, the regional office of Prison and Probation Service must consider the possibility of transferring the young person to an institution where there is access to association.

During the Ombudsman's monitoring visit to the Young offenders unit at Vestre Prison, he was informed that there were 8 places in the Young offenders unit, and that, normally, there were never more than one or two young people in the unit.

As part of his monitoring programme, the Ombudsman also visited a local prison where a 15-17-year-old asylum seeker was remanded in custody. There were no other inmates with whom the 15-17-year-old could associate. The detainee was the only minor there, and he had to stay alone in his cell for about 45 days – except for 4 days when the inmate had the company of another inmate.

On the basis of this visit the Ombudsman asked to be informed of how the regional office of the Prison and Probation Service should – in the opinion of the Department of the Prison and Probation Service – ensure observance of the rule that (if it is not possible to give the 15-17-year-old access to association) the regional office of the Prison and Probation Service must consider transferring the 15-17-year-old to an institution where there is access to association. The Department has subsequently informed the Ombudsman of the rules for transfer of 15-17–year-old inmates to another institution and stated that a news item will be posted on the intranet of the Prison and Probation Service regarding the treatment of the 15-17-year-olds.

At the time of the Ombudsman's monitoring visit to the closed prison at Nyborg, a 15-17–year-old inmate was placed in a general association block which housed 30 inmates spread out over 2 units. The 15-17-year-old was the only minor in the prison.

The Executive Order on Treatment of 15-17-year-olds does not mention Nyborg Prison as a closed prison where 15-17-year-olds can be placed. The

Ombudsman has asked the Department of the Prison and Probation Service to account for the rules governing the placement of 15-17-year-olds in closed prisons which is not mentioned in the Executive Order. In addition, the Ombudsman has asked the Ministry of Justice for the Ministry's opinion on the Department's reply.

Moreover, the Ombudsman is cognizant of another 15-17-year-old who is serving a sentence in another closed prison (not Nyborg) which is not mentioned in the Executive Order, either.

On the basis of his observations of where and under what conditions 15-17-year-olds are placed in local and state prisons, the Ombudsman has discussed the issue with the Department of the Prison and Probation Service. In connection with these discussions, the Department has stated that the problem connected with placing 15-17-year-old inmates in local and state prisons is a complex one, and that security issues also play a part in it but that the Department has a managerial focus on 15-17-year-old inmates.

3.4. Regulating association in certain closed prisons

According to the UN Convention on the Rights of the Child, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so.

During a monitoring visit to Ringe Prison, which is a closed prison, it turned out that a 17-year-old was serving a sentence together with 2 inmates of 19 and 24 years, respectively.

During a monitoring visit to a 15-17-year-old inmate at Nyborg Prison, which is also a closed prison, the 15-17-year-old was placed in a general association block which housed 30 inmates spread over 2 units. The 15-17-year-old was the only underage person in the prison. There was association in the units which each housed 15 inmates.

The rules which the Executive Order on Treatment of 15-17-year-olds has laid down regarding the association of 15-17-year-olds with adult inmates in institutions under the Prison and Probation Service do not apply to these 2 closed prisons.

The Ombudsman has therefore asked the Department of the Prison and Probation Service what rules govern the association of 15-17-year-olds with adult inmates in these 2 closed prisons. The Ombudsman has asked the Ministry of Justice for the Ministry's opinion on the Department's reply.

3.5. Knowledge of rules regarding young people in local and state prisons

According to the UN Convention on the Rights of the Child, every child deprived of liberty shall be treated in a manner which takes into account the needs of his or her age (cf. 3.1. above).

The Executive Order on Treatment of 15-17-year-olds lays down rules on the treatment of 15-17-year-olds who are placed in the Prison and Probation Service institutions. The Executive Order is prepared with reference to the UN Convention on the Rights of the Child. In addition, the Executive Order on Use of Means of Restraint in State and Local Prisons stipulates that a physician must be summoned immediately if a 15-17-year-old as an exception is placed in a security cell.

The purpose of the youth rules is to ensure that due regard is shown for 15-17-year-olds placed in local and state prisons. It is crucial in this context that the staff, including the health service staff, know the rules.

The Ombudsman recommended to a local prison that the special rules applying to 15-17-year-olds be mentioned in the instructions to the staff or that management otherwise ensured that staff were familiar with the special rules applying to 15-to-17-year-olds.

It was recommended to another local prison to ensure that staff at the local prison were familiar with the special rules applying to 15-to-17-year-olds when receiving a minor. It was recommended to the same local prison that health service staff have special focus on minors' need for medical services, including a follow-up on implemented health service measures.

The monitoring visits to the 2 local prisons caused the Ombudsman to ask the Department of the Prison and Probation Service how the regional office of prison and probation service – in the Department's opinion – should ensure that staff were familiar with the special rules applying to 15-17-year-olds.

The Department has made a statement to the Ombudsman regarding various new initiatives.

The Ombudsman has asked to be informed of the new initiatives intended to ensure a uniform compliance with the special rules applying to 15-17-year-old inmates.

The Ombudsman has also asked to be informed of whether the authorities in connection with the new initiatives will consider or have considered if training in the rules pertaining to 15-17-year-old inmates should be included in the theoretical part of prison officer training.

In connection with a monitoring visit to a state prison where a 15-17-year-old was serving a sentence, it turned out that the health service staff had not taken into account that the inmate was underage.

It was recommended to the state prison that the health service staff pay more attention to minors' need for health services.

The health service staff at the state prison considered establishing a procedure for health service reception of underage inmates. The Ombudsman asked to be informed of the result of the deliberations regarding the establishment of such a procedure.

3.6. Treatment programme for young people

A prison and probation institution receiving a 15-17-year-old who has been remanded in custody or sentenced must as soon as possible – with basis in the young person's motivation and overall background – seek to establish a special treatment programme, for instance in the form of an education and activation option for that person. This is implied in the Executive Order on Treatment of 15-17-year-olds. However, the Executive Order indicates that these rules are not used in the Prison and Probation Service institutions for asylum seekers deprived of liberty.

During a monitoring visit to a Young offenders unit in a local prison, the visiting team was informed that 15-17-year-olds who were remanded in custody pursuant to section 35 of the Aliens Act were not provided with a treatment programme.

On that basis, among other things, the Ombudsman raised the issue of interpretation of the expression "asylum seekers deprived of liberty" in the Executive Order on Treatment of 15-17-year-olds.

The Department of the Prison and Probation Service informed the Ombudsman of the interpretation. In addition, the Department stated that after the Ombudsman's inquiry the Department had ensured that the local prison knew that young people remanded in custody pursuant to the Aliens Act are covered by the Executive Order and that the local prison consequently also has a duty to seek to establish special treatment programmes for them.

Following questions from the Ombudsman, the Department of the Prison and Probation Service stated that the Department was working on establishing a professional standard with guidelines for case processing in connection with incarceration of 15-17-year-olds, including guidelines for implementing special treatment programmes.

The Ombudsman has asked to be informed of the guidelines.

At the same time, the Ombudsman informed the Ministry of Justice and the Department that during monitoring visits to 2 closed prison he had been informed that the young people – like other inmates – were provided with an action plan but not a special treatment programme.

The Ombudsman has therefore asked whether the authorities in connection with the new measures (the professional standard) will consider specifying how the stipulation about establishing a special treatment programme for 15-17-year-old inmates should be interpreted with the stipulation that inmates must be provided with an action plan. The Ombudsman has asked to be informed of the result of these deliberations.

3.7. Information about rights

Pursuant to the UN Convention on the Rights of the Child, the principles and provisions of the Convention shall be made widely known to children by appropriate and active means.

Young people in local and state prisons have a number of rights, for instance to health service from a physician. In addition, special rules apply to 15-17-year-old inmates, and young people of compulsory school age are entitled to education, for instance.

It is crucial for young people to know their rights. As part of his monitoring visits, the Ombudsman has therefore obtained information about for instance written material which is aimed at the young people and informs them of their rights.

After visits to 2 Young offenders units, the Ombudsman recommended that the units consider devising written material containing information about the young people's rights and duties and written in a language targeted at young people.

The Ombudsman has previously discussed the need for written information for 15-17-year-old inmates about their rights with the Department of Prisons and Probation.

The monitoring visits to state and local prisons gave the Ombudsman grounds for again discussing the need for written information for 15-17-year-old inmates about their rights with the Department of the Prison and Probation Service, including whether there is a need for a centrally formulated written information material about the rights and duties of the young people which is written in a language targeted at young people. The Department indicated during the discussion that the Department would consider this.

Copenhagen, 2 July 2018

Jørgen Steen Sørensen

4. Appendices

4.1. List of institutions visited in 2017 as part of the child sector theme

When	Where	What
12 Jan.	'Københavns Fængsler', Vestre Fængsel	Prison section particularly for young persons remanded in custody during investigation of their case
31 Jan. – 1 Feb.	'Bakkegården', Nykøbing Sjælland	Two secure sections for children and young persons, particularly persons remanded in non-prison custody during investigation of their case. In-house school.
28 Feb. to 1 March	'Stevnsfortet', Rødvig Stevns	Two secure sections for children and young persons, particularly persons remanded in non-prison custody during investigation of their case. In-house school.
21 March to 22 March	'Grenen', Grenå	Two secure sections and a high-security section for children and young persons, particularly persons remanded in non-prison custody during investigation of their case. In-house school.
30 March	'Kolding Arrest'	Local prison particularly for persons remanded in custody during investigation of their case. The monitoring visit concerned conditions for an asylum seeker between 15 and 17 years of age who was remanded in custody.
4 April	'Kompasset', Brønderslev	Secure 24-hour residential facility for children and young persons, particularly persons remanded in non-prison custody during investigation of their case. The monitoring visit concerned conditions for a person between 15 and 17 years of age who was serving time.
9 May to 10 May	'Egely', Nørre Åby	Three secure sections and a high-security section for children and young persons, particularly persons

		remanded in non-prison custody during investigation of their case. In-house school.
5 Sept. to 6 Sept.	'Sølager', Skibby and Hundested	Three secure sections for children and young persons, particularly persons remanded in non-prison custody during investigation of their case. In-house schools.
12 Oct.	'Ringe Fængsel'	Closed prison for persons serving time. The monitoring visit focused particularly on the youth section.
13 Oct.	'Nyborg Fængsel'	Closed prison, particularly for persons serving time. The monitoring visit concerned conditions for a person aged 15 to 17 years who was serving time.

4.2. Appendix on the Ombudsman's work with themes

Themes for monitoring activities
Every year, one or more themes for the year's monitoring visits is chosen by the Ombudsman in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

The choice of theme is particularly determined by areas where there are grounds for making an extra monitoring effort. The Ombudsman will often choose a narrow theme such as security cell placement in the Prison and Probation Service. Other times, the Ombudsman will choose a broad theme, for instance children and young people who, due to a substantial and permanent impairment of their physical and/or mental function, attend or reside at an institution.

The themes give the Ombudsman with an 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 principal 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 take place at institutions where the chosen themes are relevant.

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

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.

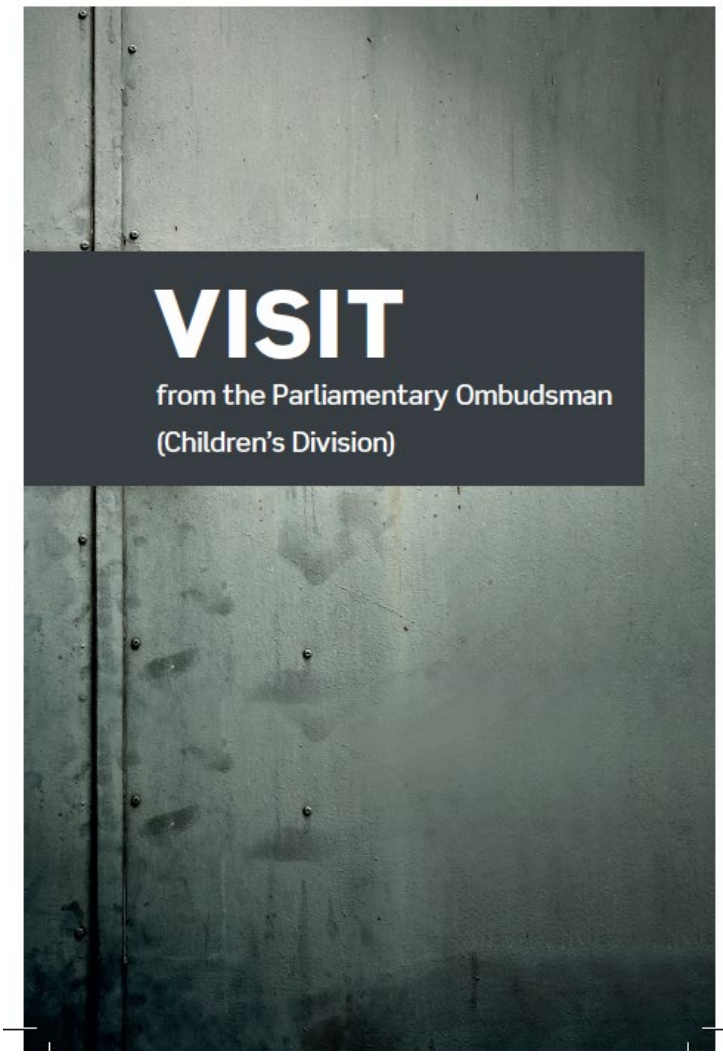
General recommendations are based on the Ombudsman's experience of the field in question. Usually, they will also have been given as concrete recommendations to particular institutions during the year's monitoring visits.

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 general 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) pursuant 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 website, www.ombudsmanden.dk. In addition, the Ombudsman will send the reports to the relevant authorities so that the authorities can include the reports in their deliberations regarding the various sectors. The Ombudsman also informs the Danish Parliament, the Folketing, about the reports.

4.3. Flyer


THE DANISH
PARLIAMENTARY
OMBUDSMAN
VISIT
from the Parliamentary Ombudsman
(Children's Division)

What

is the Parliamentary Ombudsman

The Children's Division deals with the legal rights of children and young persons.

Among other things, we check if children and young people are treated properly and get the help they are entitled to according to the law.

We visit places where children and young people are staying – especially places where they are or can be deprived of their liberty.

Children and young people can complain to us.

Why

are we visiting you

To see if you are treated with dignity, consideration and according to your legal rights.

We would like

to talk with you about

- isolation and use of physical force
- education
- how you are getting on with others, for example the other young persons