FOLKETINGETS OMBUDSMAND

Annual Report 2020

The Danish Parliamentary Ombudsman's monitoring visits as National Preventive Mechanism against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Preface

This publication is the Annual Report 2020 from the Danish Parliamentary Ombudsman as National Preventive Mechanism (NPM) under the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) to the Subcommittee on Prevention of Torture (SPT).

The contents of the publication are:

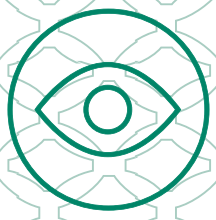
Part One: Extract of the pages from the international edition of the Danish Parliamentary Ombudsman's Annual Report 2020 which relate specifically to the Ombudsman's monitoring activities according to the OPCAT-protocol. The extracted material is unchanged from the Annual Report, and the original pagination has been maintained.

Part Two: Overviw of factual information regarding the individual monitoring visits and recommendations made in connection with the individual visits.

Part Three: Thematic reports regarding the themes that were selected for special focus in 2020. The thematic report regarding adults concerns convicted persons with intellectual and developmental disabilities. The thematic report regarding children concerns institutions for children and young people with disabilities.

Part Four: An appendix from the Annual Report about the Ombudsman and monitoring visits under the OPCAT mandate.

All the above-mentioned material is also available on www.en.ombudsmanden.dk, including the Annual Report 2020 in full.



Part One

Extract from the Danish Parliamentary Ombudsman's Annual Report 2020

Monitoring activities

Where: The Ombudsman carries out monitoring visits to places where there is a special need to ensure that citizens are treated with dignity and consideration and in accordance with their rights – because they are deprived of their liberty or otherwise in a vulnerable position.

Monitoring visits are made to a number of public and private institutions etc., such as:

- Prison and Probation Service institutions
- psychiatric wards
- social residential facilities
- residential institutions for children and young people

In addition, the Ombudsman monitors:

- forced deportations of foreign nationals
- forced deportations arranged by other EU member states at the request of the European Border and Coast Guard Agency, Frontex

Finally, the Ombudsman monitors the physical accessibility of public buildings, such as educational establishments or health institutions, to persons with disabilities.

Why: The Ombudsman's monitoring obligations follow from the Ombudsman Act and from the rules governing the following special responsibilities which the Ombudsman has been assigned:

- The Ombudsman has been designated 'National Preventive Mechanism' (NPM) under the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). 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.
- The Ombudsman has been appointed to monitor forced deportations.
- The Ombudsman monitors developments regarding equal treatment of persons with disabilities at the request of Parliament.

How: A monitoring visit to an institution is normally a physical visit by a visiting team, who speak with users, staff and the management and look at the physical environment. In 2020, however, the majority of monitoring visits were carried out as digital meetings due to COVID-19.

The monitoring of a forced deportation involves, among other things, a member of the Ombudsman's staff participating in the whole or part of the deportation.

The Ombudsman may make recommendations to the institutions visited and to the responsible authorities. Issues from the visits may also be discussed with the responsible authorities, or they may be the subject of own-initiative investigations or be dealt with in thematic reports (i.e. reports on the year's work in relation to each of the themes chosen for the year's monitoring visits).

Who: Monitoring visits are carried out by the Ombudsman's Monitoring Department, except for visits to institutions etc. for children, which are carried out by the Children's Division. External collaborative partners or consultants participate in a large proportion of visits. Depending on the type of monitoring visit, the Ombudsman collaborates with:

- medical doctors from DIGNITY – Danish Institute Against Torture
- human rights experts from the Danish Institute for Human Rights (IMR)
- wheelchair users from the Danish Association of the Physically Disabled
- consultants from the Danish Association of the Blind

Where did we go in 2020?

Monitoring visits - adults

6 Prison and Probation Service institutions

- 2 physical visits (1 of them focusing on 1 person)
- 3 partly virtual visits and 1 virtual visit

17 social residential facilities

- 12 physical visits
- 5 virtual visits

1 psychiatric ward

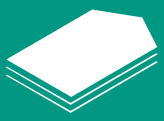
- 1 physical visit

2 police detention facilities for intoxi cated persons

- 2 physical visits

Read about the individual monitoring visits at
en.ombudsmanden.dk/visits_adults
en.ombudsmanden.dk/visits_children

Monitoring visits - children



2 private accommo dation facilities

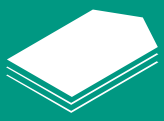
1 physical visit

1 virtual visit

6 open residential institutions

5 physical visits

1 virtual visit



2 foster families (specialised)

1 physical visit

1 virtual visit

Themes

Theme for 2020 – adults

Convicted persons with intellectual and developmental disabilities
Persons with intellectual and developmental disabilities who have committed a criminal offence are in many cases not given a prison sentence. Instead, they may be sentenced to measures aimed to prevent further offences. Such a sentence may involve placement in a social residential facility, in some cases in a secure unit. The sentence may be of indefinite duration, and it may remain in force for many years, depending, among other things, on whether the convicted person is at risk of committing further offences.

In 2020, the Ombudsman investigated the conditions for convicted persons with intellectual and developmental disabilities who have been sentenced to placement in a social residential facility.

The Ombudsman visited 17 social residential facilities approved to receive persons sentenced to placement, including the secure unit of the facility of Kofoedsminde. Seven out of the 17 facilities were run by a municipality, six by a region and four by a private party.

Five of the monitoring visits were carried out virtually on account of COVID-19.

Focus areas
During the monitoring visits to the 17 facilities, the Ombudsman's visiting teams focused particularly on the following questions:

- Are efforts made to ensure that the individual resident will no longer be at risk of committing offences, and is enough done to document these efforts?
- Does the municipality or the facility observe the rules when making decisions on applications for leave?
- Does the facility observe the special rules on use of force and other restrictions against convicted residents?
- Do residents have access to relevant treatment of mental or physical illness, and is there focus on prevention of suicide and self-harm?

Follow-up
In connection with the visits, a number of recommendations were made on matters relating to the theme for the year. For instance, the Ombudsman recommended the facilities to:

- establish what targets and initiatives are needed to ensure that residents will no longer be at risk of committing offences
- ensure documentation in relation to leave
- establish who the residents' guardian representatives are
- ensure knowledge of the special provisions of the Social Services Act on restrictions against convicted residents

Read about themes at en.ombudsmanden.dk/themes

The visits have caused the Ombudsman to open several cases on his own initiative with the responsible ministries about, among other topics, the interpretation of the rules on leave for persons sentenced to placement in a social residential facility and the rules on the supervision by municipalities for crime-prevention purposes of persons sentenced to placement.

In 2021, a report will be published which summarises the results of the visits carried out as part of the theme in the form of overall conclusions in relation to the main focus areas of the visiting teams. The report will also contain the Ombudsman's general recommendations based on the monitoring visits.

Theme for 2020 – children

Institutions for children and young people with disabilities
The institutions visited by the Ombudsman's Children's Division as part of the theme were institutions for children and young people with disabilities in a broad sense, including institutions that housed children and young people with a variety of types of physical and mental disabilities.

More specifically, the Ombudsman's visiting teams visited two private accommodation facilities and six open residential institutions (three of them regional and the other three municipal) as part of the theme. In connection with these visits, four in-house schools were also visited.

Two of the eight monitoring visits were carried out virtually on account of COVID-19.

Focus areas
During the monitoring visits carried out as part of the theme, the Ombudsman's visiting teams focused particularly on:

- use of physical force
- prevention of violence and sexual abuse and the procedure for handling suspected abuse
- education

Examples of recommendations
In connection with the visits, a number of recommendations were made on matters relating to the theme for the year. For instance, the Ombudsman recommended institutions to:

- continue endeavours to prevent and reduce the incidence of use of force
- observe deadlines for recording and reporting use of force
- consider drawing up written guidelines on prevention of violence and sexual abuse and on the procedure for handling suspected abuse
- observe the rules on teaching the full range of subjects and on the number of class hours per year
- observe the rules on exemption from subjects, compulsory tests and lower secondary school examinations

In 2021, a report will be published which summarises the results of the visits carried out as part of the theme in the form of overall conclusions in relation to the main focus areas of the visiting teams. The report will also contain the Ombudsman's general recommendations based on the monitoring visits.

Focus on fewer restrictions

COVID-19 in the Prison and Probation Service: In 2020, the Ombudsman's Monitoring Department has been investigating how the inmates of the Prison and Probation Service's institutions have been affected by COVID-19 restrictions.

After having investigated the conditions in the spring, the Ombudsman stated that it was positive that only one inmate had been infected with COVID-19. At the same time, the Ombudsman encouraged the Prison and Probation Service to review and consider whether 'a future pandemic can be handled effectively by means of less restrictive measures'.

In the autumn, the Prison and Probation Service was focusing on limiting restrictions for the inmates. For example, the inmates could, as a general rule, receive visits from close relatives. However, the conditions for the inmates were assessed on an ongoing basis and changed in the light of the gradually stricter regional and national COVID-19 restrictions. By the end of the year, 27 inmates had been infected with COVID-19, according to the Prison and Probation Service.

News item, 14 July: Ombudsman: Can a future pandemic be handled less restrictively in Prison and Probation Service institutions?

Can you ban a psychiatric patient from reading Science Illustrated?

Legal authority issue: The answer to the above question is unclear under current legislation. The Mental Health Act does not provide legal authority for censoring, for instance, Science Illustrated, historical journals or religious literature like the Secure Department of Slagelse Psychiatric Hospital ('Sikringsafdelingen') turned out to be doing during one of the Ombudsman's monitoring visits.

The Ombudsman has also encountered other types of interventions in the psychiatric sector for which there was no statutory authority. In several cases, the interventions are set out in a set of house rules and may be justified in the ward due to, for instance, health reasons, but at the same time, they are so extensive that they require statutory authority.

Therefore, the Ombudsman opened a general investigation of the authority issue with the Ministry of Health. The investigation concerned, among other subjects, the use of breathalysers and urine sampling as well as restrictions on who could visit the patients and the use of mobile phones and computers.

At the end of 2020, the Ministry stated that it would endeavour to create statutory authority. Shortly after, the Ombudsman asked the Ministry to state how it would manage the lack of statutory authority until such authority was in place.

Article: Monitoring activities: Institution status may provide questionable legal authority, page 64

Illegal use of prison cell

Cell 709: During a monitoring visit to Ringe Prison, several inmates stated consistently that one specific cell had been used to lock up inmates for a longer period when there had been trouble at a workshop. According to the inmates, there had been many people in the cell at the same time. The cell, number 709, was unfurnished.

The information was confirmed by prison guards during the monitoring visit.

A subsequent investigation by the prison showed that, in October 2018, cell 709 had been used briefly to exclude eight inmates from association at the same time to preserve order and safety.

The Department of Prisons and Probation agreed with the Ombudsman that the use of the cell was not legal. The Department wrote that, in future, the cell would only be used as a 'waiting cell' in connection with submission of urine samples – and with only one inmate at a time, as the clear starting point.

The Ombudsman finds patterns in suicide attempts

Suicide prevention: Twice in 2020, the Ombudsman has pointed to specific patterns in cases of suicide and suicide attempts in Danish state and local prisons.

Over the course of a little over a year, three inmates in Vestre Hospital, the hospital unit of the local Copenhagen prison of Vestre Fængsel, committed suicide by hanging themselves from exposed pipes in their cells.

Another pattern was that inmates in Danish state and local prisons in several cases had attempted to commit suicide using razor blades.

> **The exposed radiator pipes in the prison hospital within Vestre Fængsel were hidden while new guidelines on inmates' access to razors would contribute to the prevention of suicide using razor blades.**

In response to both situations, the Prison and Probation Service stated that the problems would be handled. The exposed radiator pipes in the prison hospital within Vestre Fængsel were hidden while new guidelines on inmates' access to razors would contribute to the prevention of suicide using razor blades.

According to an established agreement, the Parliamentary Ombudsman is notified of all deaths and suicides, and all suicide attempts and other self-harm which are highly likely to be life-threatening, among inmates of Prison and Probation Service institutions. The Ombudsman will subsequently look into, among other things, whether adequate precautionary measures had been taken, whether quick and adequate action was taken in response to the incident and whether the inmate has been provided with adequate supervision and received adequate treatment following the incident.

News item, 4 June: Measures to be taken to prevent suicides in prison

Isolated for more than eighteen months

Monitoring one person: Normally, the Ombudsman's monitoring team visits an entire institution and speaks with numerous inmates or residents. However, on occasion, as in January 2020, a monitoring visit is targeted at only one person. The Ombudsman's monitoring team conducted an announced monitoring visit to a prison inmate who had been excluded from association for more than three months.

During the visit, it turned out that the man had been isolated on various legal grounds for more than eighteen months without interruption. The Ombudsman later sent a question to the Department of Prisons and Probation asking what the Department had done and would do to stop the isolation of the inmate. The case is still pending.

In 2018 and 2019, the Ombudsman has had a special focus on inmates who periodically serve time in isolation. In 2018, focus was on inmates who were excluded from association with other inmates, while in 2019, it was on inmates in disciplinary cells. In continuation of the Ombudsman's investigation of these themes, the Prison and Probation Service has stated that it would ensure specific and adequate documentation in disciplinary cell cases by educating the staff who decide whether to use that method.

An end to secret phone detection scanning

Legal authority issue: Young people who were in surrogate custody at a secure residential institution in the north of Zealand were not allowed to have mobile phones. Therefore, upon justified suspicion, the staff would stand outside the young person's room with a scanner that could detect mobile phones through the wall. The young person would not be notified before the scanner was used. This became evident during one of the monitoring visits by the Children's Division.

Even though there may be good reasons for performing these phone detection scans, it is not legal unless the young person is made aware of it and consulted beforehand.

The then Ministry of Social and Internal Affairs said this after the Ombudsman had asked for a statement. The institution has now changed practice so that the young person will be informed before the room is searched – also when the search takes place outside the room using a scanner.

This was not the only time the monitoring team of the Children's Division encountered interventions for which there was no statutory authority. For example, visitors to a secure residential institution were searched using a scanner, among other things, before being allowed to visit.

Article: Monitoring activities: Institution status may provide questionable legal authority, page 64

Monitoring activities: Institution status may provide questionable legal authority

Kaj Larsen
Chief Legal Advisor

In his monitoring work, the Ombudsman has seen several examples of problems with the legal authority for house rules and interventions – in future, he will continue to focus on this issue.

Body searches, examination of personal belongings, urine tests, compulsory washing of clothes, examination of mail, nightly door locking and literature control.

These are some of the interventions encountered by the Ombudsman during monitoring visits in recent years where it turned out that legal authority was lacking or questionable. All these interventions were introduced due to the institutions' wishes to protect a citizen or maintain order at the institution. Thus, on the face of it, the reasons behind the interventions are good. However, many of the interventions are so extensive that they require explicit statutory authority.

In 2020, the Ombudsman published six cases concerning a lacking or questionable basis for interventions. One of the cases concerned 17 different psychiatric wards where the Ombudsman found a lack of or questionable legal authority in the house rules of the wards (Case No. 2020-43, published in Danish at www.ombudsmanden.dk).

Therefore, the Ombudsman's Monitoring Department and Children's Division continuously focus on whether interventions towards residents, patients or inmates at institutions – or visitors – have sufficient legal authority.

Written rules and institution status

The Ombudsman's Monitoring Department carries out monitoring visits to institutions especially within the Prison and Probation Service (state and local prisons etc.), psychiatric wards, social residential facilities and asylum centres. The monitoring by the Children's Office involves children and young people particularly at social institutions, private accommodation facilities and children's psychiatric wards.

If it turns out that a provision in a set of house rules or an intervention against a resident does not have legal authority in written rules (laws or executive orders), the question is often whether the unwritten principle of institution status could provide legal authority. To a certain extent, the management of an institution can establish house rules or introduce interventions

towards the residents in order to ensure that the institution can function. The legal authority for these house rules or interventions is said to be the institution status (or institution considerations).

However, there are limits to when the institution status may be recognised as legal authority:

1. It is a common assumption that the more intensive the interventions in the fundamental rights of individuals, the greater the requirements on the authority. Thus, the principle of institution status can hardly be considered to provide legal authority for interventions in personal freedom or integrity. Interventions in personal freedom and integrity could involve confinement, examination of personal belongings, mobile phone confiscation, compulsory submission of a urine sample or setting up of surveillance equipment.

2. If an intervention can be compared to something that is already expressly governed by written rules, the institution status cannot usually be recognised as legal authority. Neither for making decisions nor establishing rules such as house rules.

3. The institution status does not generally provide legal authority for interventions that have previously been – but no longer are – governed by written rules.

Ban against certain kinds of literature

Thus, the institution status can often only provide legal authority for less extensive interventions or provisions of house rules. Such provisions might concern when a ward should be quiet, visitation hours, where smoking is allowed and the institution's alcohol policy.

In 2020, the Ombudsman found the institution status to provide insufficient legal authority in several cases.

During a monitoring visit to the Secure Department of Slagelse Psychiatric Hospital ('Sikringsafdelingen'), which is especially targeted at patients who are sentenced to placement and treatment in a hospital, the visiting team found that the Secure Department had restricted some patients' access to literature (Case No. 2020-16). Among others, the visiting team spoke with a patient who was not allowed to read religious literature, historical journals or the magazine Science Illustrated. A different patient was not allowed to read books on psychiatry.

The management of the Secure Department said that several patients suffered from delusions, which might be worsened by too many stimuli. There were thus therapeutic reasons behind the Secure Department's decision to keep the patients from reading certain literature.

As legal authority for these interventions, the authorities referred to a provision in the Mental Health Act concerning house rules and to the principle of institution status.

The Ombudsman stated that the restriction interfered with the patients' right to receive information under Article 10 of the European Convention of Human Rights, and that interference with the freedom of individuals requires clear and unambiguous legal authority. The Ombudsman believed that the provision of the Mental Health Act on house rules does not in itself provide the required legal authority. It seems that the institution status also did not provide legal authority for the interventions,

since limiting the right to receive information was an extensive intervention.

The Ministry of Health recognised the problem and would work towards creating clear legal authority.

Greater legal protection through written rules

In several cases, the Ombudsman's statements have led to an institution's previously questionable legal practice being replaced by actual legislation. A significant example is the opportunity afforded by the Social Services Act to establish restrictions for visitors to care homes etc. (Case No. 2010 20-7).

Legislation will generally increase legal protection. The provisions of an act will typically state when interventions can be taken. In this way, it is also indirectly stated when they *cannot* be taken. This is not the case when the institution status provides the legal authority. Legislation will typically also include provisions on special documentation requirements and complaint options. Therefore, written rules normally reduce the risk of interventions being taken in practice without the required legal authority. At the same time, written rules provide a more secure basis for the Ombudsman and other reviewing bodies to assess the legal authority for specific interventions.

In addition, law-making naturally gives the legislative power a chance to consider which provisions should apply in the area. This ensures that the sometimes difficult balancing between the civic rights of the citizens and the objective considerations behind an intervention is carried out by Parliament with the resulting democratic credibility.

A voluntary agreement must in fact be voluntary

In the psychiatric sector, the Ombudsman has many times been informed that patients have voluntarily entered into agreements about interventions. For example, this was the case during a visit to the Secure Department, where two patients had entered into an agreement on a transition from having their doors locked (Case No. 2020-15). The Secure Department had previously decided that the doors of the two patients would be locked – the Mental Health Act provided legal authority for this. It was later decided that the doors should no longer be locked, but the patients would still not be allowed to leave their rooms. Whenever they wanted to go to the common rooms, they would first have to call the staff, and then the staff would collect them and lead them out of their rooms.

Voluntary agreements are generally in keeping with the fundamental principle of the patient's right of self-determination set out in the Health Act, which also applies in the psychiatric sector. The Mental Health Act thus states that admission, stays and treatment at psychiatric wards must to the extent possible take place with the consent of the patient. Force cannot be used until every possible attempt has been made to convince the patient to participate voluntarily.

However, in the case from the Secure Department and another case from 2020 (Case No. 2020-25), the Ombudsman has pointed out that psychiatric wards must ensure that such agreements are in fact voluntary – not forced. In order for an agreement to be valid, it must have been entered into voluntarily, based on satisfactory information and by a patient who is able to give valid consent. Otherwise, it is considered

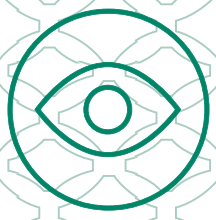
illegal force, regardless of the intentions of the staff. It is also important that the patients are aware that they can back out of an agreement at any time without automatically being met by sanctions because of it.

In recent years, there have been relatively many cases in the psychiatric sector where the Ombudsman has found a lack of or questionable legal authority for interventions or where it has been questionable whether there was valid consent for an intervention. This has contributed to the Ombudsman placing special focus in 2021 on force and non-statutory measures and interventions in the psychiatric sector in connection with monitoring visits. In the spring of 2022, the Ombudsman will summarise the most important results in a thematic report.

The Ombudsman's cases about legal authority

The Ombudsman's cases about lack of legal authority in house rules and for specific interventions as well as the legislative developments in the area are characterised by the following:

- The cases are often opened on the Ombudsman's own initiative in connection with monitoring visits.
- The institutions' house rules and interventions are typically aimed at residents, patients or inmates, who rarely complain about the issues to the Ombudsman.
- In several cases, the Ombudsman has expressed understanding of the professional views behind the provisions of house rules or specific interventions.
- When the Ombudsman finds legal authority to be lacking or questionable, he usually involves the relevant ministry in order for the ministry to consider whether authority based on written rules is needed.
- Over time, there is a tendency for the framework of the institutions' house rules and specific interventions to be increasingly governed by written law. The increase in legislation naturally reduces the area where the institution status can be considered to provide relevant legal authority.
- If there are written rules that govern specific types of interventions, the institution status generally does not provide legal authority for comparable interventions. This also applies to interventions of a less intensive character.
- The Ombudsman will continue to focus on the issue of interventions without legal authority – also in connection with monitoring visits.



Part Two

Overview of factual information regarding the individual monitoring visits and recommendations

Overview: Monitoring visits to institutions for adults in 2020

The overview below shows the institutions etc. visited, with a description of each. In addition, it shows the number of talks we had with users (inmates, resi-dents, patients etc.) and with relatives etc. (relatives, guardians, social guard-ians of persons under a residential care order and patient advisors). The Om-budsman 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. It is stated for each visit whether DIGNITY and/or IMR participated. Finally, the recommen-dations made in connection with the individual visit are presented.

MONITORING VISITS	NO. OF VISITS
NO. OF VISITS	26
TALKS WITH USERS	128
TALKS WITH RELATIVES ETC.	59
WITH DIGNITY	25
WITH IMR	14
ANNOUNCED/ UNANNOUNCED VISITS	25/1
PHYSICAL/PARTLY VIRTUAL/VIRTUAL VISITS	17/3/6
CONCLUDED WITH RECOMMENDATIONS	24
CONCLUDED WITHOUT RECOMMENDATIONS	2

MONITORING VISITS

'Politigårdens Fængsel'
Closed prison section mainly for 'negatively strong' prisoners. The monitoring visit concerned the conditions for an inmate who had been excluded from association for a long time.
Talk with 1 user
DIGNITY and IMR participated

Recommendations

- that management ensure a greater focus on the inmate understanding what is being said during conversations about his situation and rights and during consultations with healthcare staff, and that interpreters be used to a greater extent

- that management, to the greatest extent possible, give the inmate the possibility to work

'Bostedet Kysten', Nysted
Municipal social residential and daytime facility for adults with substantially and permanently impaired mental functioning, including persons under a residential care order
Talks with 3 users and 2 relatives etc.
DIGNITY participated

Recommendations

- that management try to establish who the residents' social guardians are, for instance by asking the residents or contacting the court

'Botilbuddet Granhøjen', Holbæk
A unit of a private social residential and daytime facility for adults with, for instance, intellectual and developmental disabilities, including persons under a residential care order
Talks with 2 users
DIGNITY participated

Recommendations
The monitoring visit did not give rise to any recommendations.

'Botilbuddet Bo og Naboskab Sydlolland', Rødby
Regional social residential and activity facility for adults with substantially and permanently impaired mental functioning, including persons under a residential care order
Talks with 3 users and 3 relatives etc.
DIGNITY and IMR participated

Recommendations

- that management try to establish who the residents' social guardians are, for instance by contacting the court

- that management update the internal guidelines on leave to (a) give correct information on when the state prosecutor has the power to grant leave and (b) reflect – with respect to the delegation by municipalities to the facility – the facility's practice

- that management ensure adequate documentation in relation to leave, with details of, among other things, starting and end time, whether escorted or unescorted and whether any problems arose

'Startskuddet, Botilbuddet Jupiter', Mern

Independent institution with social residential and daytime facility for adults with, for instance, intellectual and developmental disabilities, including persons under a residential care order
Talks with 2 users and 2 relatives etc.
DIGNITY and IMR participated

Recommendations

- that management ensure adequate records are made in relation to leave, with details of, among other things, starting and end time, whether escorted or unescorted and whether any problems arose

- that management ensure staff are familiar with the rules of the Executive Order on Leave and on how leave must be recorded

- that management ensure the guidance on use of force is updated to be in line with the applicable rules and expanded to include information about the special rules applicable for persons placed in a social residential facility under a residential care order, cf. Part 24 d of the Social Services Act

- that management provide more specific information in the facility's guidelines on violence and threats about what must be recorded, and that management describe its duty to report violence, threats and other criminal offences to the police

- that management ensure the guidelines on violence and threats are observed

- that management ensure self-harm, suicide attempts and suicides are recorded with a view to analysing patterns and causes

- that management ensure the directions on procedures to be followed in cases of suicide attempts or threats of suicide are updated with a description of procedures for precautionary measures

- that management bring the house rules in line with the applicable rules

Own-initiative case opened about the supervision by the municipality for crime-prevention purposes of one resident

'Kofoedsminde', Rødby
Regional secure facility for adults with intellectual and developmental disabilities, including persons under a residential care order
Talks with 23 users and 2 relatives etc.
DIGNITY and IMR participated

Recommendations

- that searches of residents be carried out in a separate room and not in the presence of other residents

- that residents be informed in writing, in a way considered relevant by management – for instance in the house rules – that any violence, threats or other abuse will be reported to the police and that this may have a negative impact on the possibility of having a residential care order relaxed or discharged

- that management ensure, in a way which it considers relevant, that staff are given a clear understanding of how issues relating to hashish trafficking are to be handled

- that guidance or directions for staff regarding prevention and handling of drug abuse be drawn up

'Særforanstaltningen Lindegården', Odense
Municipal social residential facility for adults with, for instance, intellectual and developmental disabilities and externalising behaviour, including persons under a residential care order
Talks with 2 users and 2 relatives etc.
DIGNITY participated

Recommendations

- that management ensure that also escorted leave is documented, for instance in the leave log

- that management ensure the directions on the procedure for recording and reporting use of force etc. are updated to include guidelines on, among other things, guidance on complaining

- that management ensure only general guidelines are laid down in the house rules

- that management and healthcare staff ensure continued focus on correct handling of medicines and enter into a dialogue with the municipality about the items in the municipality's medicine handling directions which in management's opinion make the handling of medicines difficult – and thus riskier – in this type of facility

'Psykiatrisk Afdeling Odense'
Two integrated bed units of psychiatric ward
Talks with 7 users and 1 relative etc.
DIGNITY and IMR participated

Recommendations

- that management ensure the standard form used for records of use of forcible restraint is designed to enable the addition of the compulsory information under section 5 of the Executive Order on, among other subjects, records and reporting of use of coercive measures

- that management ensure the names of the staff members involved are entered into records of use of coercive measures

- that management ensure that, throughout a period of forcible restraint, a renewed assessment is carried out by a physician at least three times over a 24-hour period, at regular intervals, of whether forcible restraint may be continued

- that management ensure the guidelines on involuntary commitment and other use of coercive measures in psychiatric care clearly state when forcible restraint must be terminated under the applicable legislation

- that management ensure the units are aware that debriefings must be carried out systematically in accordance with the applicable rules

- that management ensure constant surveillance of patients without their consent is handled in accordance with the provisions of section 18 d of the Act on Use of Coercive Measures in Psychiatric Care Etc. and section 39 of the Executive Order on Use of Coercive Measures Other Than Involuntary Commitment in Psychiatric Wards

- that management ensure more specific information is included in the house rules about the consequences of violations of the rules

- that management consider adopting specific recording of violence and threats among patients for the purpose of documentation, knowledge and learning

- that management ensure guidelines are drawn up on prevention of and follow-up on violence and threats among patients

- that management keep up its creditable efforts so that the two psychiatric units can continue to offer dialogue with management and staff of wards with somatic patients with a view to reducing the use of coercive measures against somatic patients

'Specialcenter Syddanmark, Midgårdhus', Ribe
Regional social residential and occupational facility for adults with intellectual and developmental disabilities, including persons under a residential care order
Talks with 1 user and 6 relatives etc.
DIGNITY participated

Recommendations

- that management ensure local directions on the handling of medicines are drawn up in accordance with the guidance notes issued by the Danish Health Authority on the drawing up of directions and that the staff of the facility are trained in the directions

- that management adopt specific recording of violence and threats among residents for the purpose of documentation, knowledge and learning

- that the guidance on, among other things, the types of incidents which may and the types which must be reported to the police, and how this must be done, be amended to state clearly that it also encompasses incidents among residents

- that residents be informed about the facility's policy on what is reported to the police, and that management inform residents – in a

way which it considers relevant – about the possible consequences of being reported to the police, including that this may have a negative impact on the possibility of having a residential care order relaxed or discharged

'Specialcenter Syddanmark, Østruplund', Otterup
Regional social residential and occupational facility for adults with intellectual and developmental disabilities, including persons under a residential care order
Talks with 4 users and 2 relatives etc.
DIGNITY participated

Recommendations

- that management adopt specific recording of violence and threats among residents for the purpose of documentation, knowledge and learning

- that management ensure local directions on the handling of medicines are drawn up in accordance with the guidance notes issued by the Danish Health Authority on the drawing up of directions and that the staff of the facility are trained in the directions

- that the guidance on, among other things, the types of incidents which may and the types which must be reported to the police, and how this must be done, be amended to state clearly that it also encompasses incidents among residents

- that residents be informed about the facility's policy on what is reported to the police, and that management inform residents – in a way which it considers relevant – about the possible consequences of being reported to the police, including that this may have a negative impact on the possibility of having a residential care order relaxed or discharged

'Ørum Bo- og aktivitetscenter, Afdeling Nyvang'
Municipal social residential facility for adults with mental challenges or a special need for intensive support in a residential environment, including persons under a residential care order
Talks with 1 user and 2 relatives etc.
DIGNITY participated

Recommendations

- that management ensure the section on social guardians in the manual for staff on persons with intellectual and developmental disabilities under a residential care order is amended to include information

about the duty under the Executive Order on Social Guardians to provide information to social guardians

- that management try to establish who the residents' social guardians are, for instance by contacting the court

- that management ensure the guidance in the pre-printed forms for applications for leave are brought into line with the facility's practice by deletion of the incorrect information that applications must be sent to the principal of the facility at least 14 days in advance

- that management ensure the guidance on complaining about use of force and other restrictions includes guidance on the applicable deadlines for complaints and that residents are given relevant and adequate information about the deadlines

- that management ensure written guidelines are drawn up on violence and threats of violence among residents which include, among other things, guidelines on how to handle the victim and perpetrator and any residents not directly involved in the incident and guidelines on how to follow up towards the respective residents, including on questions in relation to reporting incidents to the police

'Pension Engelsborg', Kongens Lyngby
Halfway house under the Prison and Probation Service, particularly for persons who are serving the last part of their sentence or who are under supervision. The visit was carried out as part of the Ombudsman's monitoring of the conditions in Prison and Probation Service institutions during the COVID-19 period.
Talks with 3 users
DIGNITY and IMR participated

Recommendations

- that the Prison and Probation Service review its experiences from the COVID-19 period with a view to determining whether any future epidemics – or serious outbreaks of disease with a particular risk of spreading in Prison and Probation Service institutions – can be handled effectively but at the same time by means of less restrictive measures

- that the Department of Prisons and Probation consider on an ongoing basis during any future epidemics – or serious outbreaks of disease with a particular risk of spreading in Prison and Probation Service institutions – whether there is a basis for drawing up guidelines targeted to the conditions in halfway houses under the Prison and

Probation Service

- that the Department consider laying down written guidelines on the prevention of adverse psychological effects of isolation due to COVID-19 or any future epidemics or serious outbreaks of disease with a particular risk of spreading in Prison and Probation Service institutions, and that these guidelines focus particularly on alternative ways in which inmates can have meaningful human contact, including with non-relatives, and keep themselves occupied

- that, during the COVID-19 pandemic and any future epidemics – or serious outbreaks of disease with a particular risk of spreading in Prison and Probation Service institutions – the Department and the managements of Prison and Probation Service institutions ensure to a greater extent that inmates are informed about guidelines on prevention of the spread of infection and about restrictions on their rights etc. in a language which they understand in order that all inmates will receive adequate information

- that the Department and the managements of Prison and Probation Service institutions analyse the causes of the lower incidence of, among other things, violence and threats of violence, use of force, placements in security cells and disciplinary sanctions during the COVID-19 period for the purpose of preventing such incidents during times of normal conditions

'Blegdamsvejens Arrest'
Local prison particularly for persons remanded in custody during investigation of their case. The visit was carried out as part of the Ombudsman's monitoring of the conditions in Prison and Probation Service institutions during the COVID-19 period.
Talks with 5 users
DIGNITY and IMR participated

Recommendations

- that the Prison and Probation Service review its experiences from the COVID-19 period with a view to determining whether any future epidemics – or serious outbreaks of disease with a particular risk of spreading in Prison and Probation Service institutions – can be handled effectively but at the same time by means of less restrictive measures

- that the Department of Prisons and Probation consider on an ongoing basis during any future epidemics – or serious outbreaks of dis-

ease with a particular risk of spreading in Prison and Probation Service institutions – whether there is a basis for drawing up guidelines targeted to the conditions in halfway houses under the Prison and Probation Service

- that the Department consider laying down written guidelines on the prevention of adverse psychological effects of isolation due to COVID-19 or any future epidemics or serious outbreaks of disease with a particular risk of spreading in Prison and Probation Service institutions, and that these guidelines focus particularly on alternative ways in which inmates can have meaningful human contact, including with non-relatives, and keep themselves occupied

- that, during the COVID-19 pandemic and any future epidemics – or serious outbreaks of disease with a particular risk of spreading in Prison and Probation Service institutions – the Department and the managements of Prison and Probation Service institutions ensure to a greater extent that inmates are informed about guidelines on prevention of the spread of infection and about restrictions on their rights etc. in a language which they understand in order that all inmates will receive adequate information

- that the Department and the managements of Prison and Probation Service institutions analyse the causes of the lower incidence of, among other things, violence and threats of violence, use of force, placements in security cells and disciplinary sanctions during the COVID-19 period for the purpose of preventing such incidents during times of normal conditions

'Nyborg Fængsel'
Sections for persons sentenced to deportation in closed prison. The visit was carried out as part of the Ombudsman's monitoring of the conditions in Prison and Probation Service institutions during the COVID-19 period.
Talks with 12 users
DIGNITY and IMR participated

Recommendations

- that the Prison and Probation Service review its experiences from the COVID-19 period with a view to determining whether any future epidemics – or serious outbreaks of disease with a particular risk of spreading in Prison and Probation Service institutions – can be handled effectively but at the same time by means of less restrictive measures

- that the Department of Prisons and Probation consider on an ongoing basis during any future epidemics – or serious outbreaks of disease with a particular risk of spreading in Prison and Probation Service institutions – whether there is a basis for drawing up guidelines targeted to the conditions in halfway houses under the Prison and Probation Service

- that the Department consider laying down written guidelines on the prevention of adverse psychological effects of isolation due to COVID-19 or any future epidemics or serious outbreaks of disease with a particular risk of spreading in Prison and Probation Service institutions, and that these guidelines focus particularly on alternative ways in which inmates can have meaningful human contact, including with non-relatives, and keep themselves occupied

- that, during the COVID-19 pandemic and any future epidemics – or serious outbreaks of disease with a particular risk of spreading in Prison and Probation Service institutions – the Department and the managements of Prison and Probation Service institutions ensure to a greater extent that inmates are informed about guidelines on prevention of the spread of infection and about restrictions on their rights etc. in a language which they understand in order that all inmates will receive adequate information

- that the Department and the managements of Prison and Probation Service institutions analyse the causes of the lower incidence of, among other things, violence and threats of violence, use of force, placements in security cells and disciplinary sanctions during the COVID-19 period for the purpose of preventing such incidents during times of normal conditions

'Botilbuddet Lærkely', Tønder
Municipal social residential and occupational facility for adults with intellectual and developmental disabilities, including persons under a residential care order
Talks with 3 users
DIGNITY and IMR participated

Recommendations
- that management try to establish who the residents' social guardians are, for instance by contacting the court

- to ensure residents are informed about the facility's policy on what is reported to the police

- that medicine boxes with poured-out medicines be marked with the resident's name and civil registration number

'De 2 Gårde, Fuglekærgård', Vejle
Municipal social residential facility for adults with, for instance, intellectual and developmental disabilities, including persons under a residential care order
Talks with 5 users and 6 relatives etc.
DIGNITY participated

Recommendations

- that management ensure the facility draws up written guidelines on prevention and handling of incidents involving violence or threats among residents

- that management ensure the facility expands its written guidelines on reporting criminal offences committed by residents against fellow residents to the police with guidelines on when violence, threats and other abuse are to be reported to the police

- that management ensure the facility informs residents in writing – in a way considered relevant by management – about the facility's guidelines on reporting criminal offences to the police and that being reported to the police for committing a criminal offence may have a negative impact on the possibility of having a residential care order relaxed or discharged

The police detention facility in Vejle
Police detention facility particularly for persons who are unable to take care of themselves due to intoxication and who have been encountered in a dangerous situation by the police
DIGNITY participated

Recommendations
The monitoring visit did not give rise to any recommendations.

'Svendborg Arrest'
Local prison particularly for persons remanded in custody during investigation of their case
Talks with 9 users
DIGNITY and IMR participated

Recommendations

- that management ensure non-Danish-speaking inmates are offered addiction treatment (pre-treatment) on an equal footing

with Danish-speaking inmates

- that management ensure interpreters are used when necessary, including at arrival interviews

- that management ensure the culture according to which it is not acceptable to call a prison guard in the evening or at night in order to use the toilet is changed, and that management ensure inmates who call a prison guard at night in order to use the toilet wait the shortest possible time – and not more than 20 minutes – except under special circumstances

'Snåstrup Vestergaard', Aarhus
Municipal social residential and occupational facility for adults with intellectual and developmental disabilities, including persons under a residential care order
Talks with 3 users and 3 relatives etc.
DIGNITY and IMR participated

Recommendations

- that management ensure that sub-targets and initiatives which are necessary for and part of crime prevention measures are described in the facility's targets based on crime prevention targets in the municipality's action plans for residents

- that management establish the possibilities for relevant addiction treatment which takes the needs of oligophrenic persons into account

- that management ensure pedagogical efforts have more focus on preventing drug abuse

- that management try to establish who the residents' social guardians are, for instance by contacting the court

- that management ensure the facility gives residents' social guardians any information necessary for them to carry out the function of social guardian adequately

- that management ensure documentation in relation to leave (leave records), with details of, among other things, starting and end time, whether escorted or unescorted and whether any problems arose

- that management ensure staff are instructed in the content of the provisions of Part 24 of the Social Services Act on use of force and

other restrictions and of the provisions of Part 24 d of the Act on restrictions which may be taken against persons placed in a social residential facility under a residential care order, and that in this connection management consider, among other things, drawing up directions on use of force

- that management ensure a greater focus on precise and adequate documentation in reports on use of force and other restrictions under the Social Services Act

'Nørholm Kollegiet', Herning
Four units of a regional social residential facility for adults with intellectual and developmental disabilities, including persons under a residential care order
Talks with 6 users and 7 relatives etc.
DIGNITY and IMR participated

Recommendations

- that management ensure, in a way which it considers relevant, that measures are taken against residents who do not comply with the terms for leave and that these measures are documented

- that management ensure, in a way which it considers relevant, that staff know how to handle situations in which residents return from leave under the influence

The police detention facility in Aarhus
Police detention facility particularly for persons who are unable to take care of themselves due to intoxication and who have been encountered in a dangerous situation by the police

Recommendations

- that management ensure that, in accordance with section 14(2) of the Executive Order on Placements in Police Detention Facilities, persons placed in the facility are checked on in person following the medical examination

- that management ensure the Danish Medical Association’s form for medical examinations is used

'Botilbuddet Sødisbakke', Mariager
Regional social residential facility for adults with intellectual and developmental disabilities, including persons under a residential care order
Talks with 4 users and 8 relatives etc.
DIGNITY participated

Recommendations

- that management ensure residents are informed about the facility's policy on what is reported to the police, and that management inform residents – in a way which it considers relevant – that being reported to the police may have a negative impact on the possibility of having a residential care order relaxed or discharged

- that management ensure guidelines are drawn up on prevention and handling of suicides, suicide attempts and self-harm and on how to analyse the causes of the incidents

'Jyderup Fængsel'
Open prison for men with closed section for women
Talks with 19 users
DIGNITY and IMR participated

Recommendations

- that management ensure inmates are informed about guidelines on prevention of the spread of infection and about restrictions on their rights etc. on account of COVID-19 in a language which they understand in order that all inmates will receive adequate information

- that management ensure the time an inmate has been temporarily excluded from association prior to placement in a disciplinary cell is deducted from the length of time the inmate is to spend in the disciplinary cell

- that management ensure staff offer inmates in disciplinary cells the possibility to spend at least an hour daily in fresh air, cf. section 43(3) of the Sentence Enforcement Act

- that management ensure healthcare staff are able to get an overview of all exclusions from association and disciplinary cell placements and the expected duration of disciplinary cell placements

- that the directions regarding copying of medical records be adapted to be in line with the prison's practice and so that uniformed staff do not have access to health information which they are unlikely to need

- that focus be increased on passing on requests from inmates to speak with a doctor or nurse directly to relevant healthcare staff

- that focus be increased on the practical handling of medicines by prison guards, including that healthcare staff be informed in the event of unintended incidents in this connection in order that they will be

able to follow up

- that management – if necessary in cooperation with the Regional Office and the Department of Prisons and Probation – ensure that female inmates in need of addiction treatment who cannot be transferred to round-the-clock treatment are offered the necessary outpatient treatment instead

- that management draw up a procedure to ensure that any needs of inmates as a result of impaired physical functioning are taken into account

- that management ensure unauthorised persons will not be able to see sensitive personal information about other inmates in the office

'Fonden Sparta', Sunds
Private social residential facility for adults with intellectual and developmental disabilities, including persons under a residential care order
Talk with 1 relative etc.
DIGNITY participated

Recommendations

- that management draw up written guidelines on when criminal offences are reported to the police

- that residents be informed about the facility's policy on what is reported to the police, and that management inform residents – in a way which it considers relevant – about the possible consequences of being reported to the police, including that this may have a negative impact on the possibility of having a residential care order relaxed or discharged

- that management ensure suicides, suicide attempts and self-harm are recorded with a view to analysing patterns and causes

- that management ensure guidelines are drawn up on prevention and handling of suicides, suicide attempts and self-harm

- that the facility's house rules be updated to be in line with its practices and to clearly state which rules are only applicable for residents under 18 years of age

- that the facility's directions on use of force and its safety manual be updated to be in line with the applicable rules of the Social Services

Act and to clearly state which rules are applicable for residents over 18 years of age

'Behandlingscentret Hammer Bakker', Vodskov
Municipal treatment centre for adults with mild intellectual and developmental disabilities coupled with psychiatric disorders and/or severe emotional problems, including persons under a residential care order
Talks with 7 users and 3 relatives etc.
DIGNITY participated

Recommendations

- that management draw up local guidelines on use of force

- that in future management record and keep statistics on the incidence of violence and threats of violence among residents, and that the statistics be analysed on a continuous basis to find causes and patterns

- that management ensure residents are informed about the facility's policy on what is reported to the police, and that management inform residents – in a way which it considers relevant – that being reported to the police may have a negative impact on the possibility of having a residential care order relaxed or discharged

'Ekkofonden', 'Alternativet I & II', Hjørring
Private social residential facility for adults with substantially and permanently impaired mental functioning, including persons under a residential care order
Talks with 3 users and 4 relatives etc.
DIGNITY participated

Recommendations

- that management ensure guidelines are drawn up on staff assisting residents with handling their finances, including on the use of NemID (the digital signature which is used as a single login for public websites, online banking and many other websites and services in Denmark)

- that management ensure the facility has the necessary information about the criminal offences for which residents have been convicted and about the terms of their placement in the facility

Overview: Monitoring visits to institutions etc. for children in 2020

The overview below shows the institutions etc. visited, with a description of each. In addition, it shows the number of talks we had with children and young peo-ple (referred to below as ‘users’) and with relatives and, if relevant, guardians (referred to below as ‘relatives etc.’). The Ombudsman collaborates with DIG-NITY – 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. It is stated for each visit whether DIGNITY and/or IMR participated. Finally, the recommendations made in connection with the individual visit are presented.

MONITORING VISITS	NO. OF VISITS
NO. OF VISITS	10
TALKS WITH USERS	31
TALKS WITH RELATIVES ETC.	57
WITH DIGNITY	9
WITH IMR	5
ANNOUNCED/ UNANNOUNCED VISITS	9/1
PHYSICAL/ VIRTUAL VISITS	7/3
CONCLUDED WITH RECOMMENDATIONS	9
CONCLUDED WITHOUT RECOMMENDATIONS	1

MONITORING VISITS

'Hollænderhusene', Næstved

Municipal residential institution for children and young people with severe physical, mental and cognitive disabilities
Talks with 1 user and 6 relatives etc.
DIGNITY participated

Recommendations
The visiting team recommended that 'Hollænderhusene':

- continue endeavours to prevent and reduce the incidence of use of force

- consider drawing up internal guidelines on use of physical force which explain, in an easy-to-understand way, the powers of staff in relation to use of physical force, including how they are permitted to use physical force

- ensure the holders of parental responsibility – and to the extent possible also the children and young people themselves – are informed about their rights in relation to use of force and other restrictions on the right of self-determination, including about their right to complain, on the children and young people's arrival

- observe deadlines for recording and reporting use of force

- continue the process of drawing up written guidelines on how violence and sexual abuse are to be prevented and the procedure for handling suspected abuse

- continue the process of implementing its new medicine handling directions

- update its medicine handling directions to include the handling of medicines for children in respite care, clarification on the handling of non-prescribed products (such as dietary supplements) which parents want their children to take and detailed directions on pouring out 'as required' medicines

The visit caused the Ombudsman to open two cases on his own initiative about the institution's use of beds with high sides and its locking system, respectively.

'Himmelev Behandlingshjem', Hvalsø

Regional residential institution for children and young people with autism spectrum disorders
In-house school
Talks with 5 users and 3 relatives etc.
DIGNITY participated

Recommendations
The visiting team recommended that 'Himmelev Behandlingshjem':

- continue endeavours to prevent and reduce the incidence of use of force
- observe deadlines for recording and reporting use of force
- expand its written guidelines on prevention of violence and sexual abuse and the procedure for handling suspected abuse, and ensure focus on the children learning, to the extent relevant, to handle their sexuality
- update, in collaboration with the municipality of location, the agreement on schooling in the in-house school (with regard to current rules and factual information)
- ensure compliance with the rules on teaching the full range of subjects and on reduction of the number of class hours per year
- ensure compliance with the rules on exemption from subjects and from compulsory national tests and lower secondary school examinations
- ensure the staff of the in-house school know the scope of the Act on Adult Responsibility for Children and Young Persons in Out-of-Home Care
- continue to consider how its directions on the handling of medicines and on health matters can be made more practical to use for staff
- ensure consistency between the directions and practical medicine handling guidance hanging on walls

The visit caused the Ombudsman to open four cases on his own initiative about children placed in the institution not having an action plan.

Foster family, Central Denmark Region
Specialised foster family
Talks with 3 users and 2 relatives etc.
IMR participated

Recommendations
The monitoring visit did not give rise to any recommendations.

'Specialområde Børn og Unge, afd. Ulfborghus', Ulfborg
Regional residential institution for children and young people with an autism spectrum diagnosis or autism-like traits coupled with significant specific learning difficulties or an intellectual or developmental disability
In-house school
Talks with 4 users and 5 relatives etc.
DIGNITY and IMR participated

Recommendations
The visiting team recommended that 'Ulfborghus':

- observe deadlines for recording and reporting use of force
- ensure compliance with the rules on exemption from subjects and documentation of this
- ensure compliance with the rules on exemption from compulsory national tests and lower secondary school examinations and documentation of this
- update, in collaboration with the municipality of location, the agreement on schooling in line with the applicable rules
- draw up local directions on the handling of medicines, including the dispensing and administration of regular and ‘as required’ medicines, which comply with the guidance notes issued by the Danish Health Authority on the drawing up of directions

'Ravnbjerghus', Hadsund
Private accommodation facility for children and young people with milder to more severe mental retardation or with autism spectrum disorders and in some cases also with minor physical disabilities
Talks with 2 users and 3 relatives etc.
DIGNITY participated

Recommendations
The visiting team recommended that 'Ravnbjerghus':

- continue endeavours to ensure that staff have an adequate knowledge of the rules on use of force of the legislation on adult responsibility for children and young persons in out-of-home care

- continue endeavours to prevent and reduce the incidence of use of force

- consider expanding its internal guidelines on use of physical force to include (a) a description of the rules on physical guiding and on briefly holding or leading a person away when this is necessary to prevent substantial damage to property, (b) information about deadlines for recording and reporting and (c) information about how it is permitted to use physical force

- ensure children, young people and holders of parental responsibility are also informed about their complaint options when they are informed, on the children and young people's arrival, about their rights in relation to use of force and other restrictions on the right of self-determination

- ensure an adequate description of the course of events (both before and during the incident) is provided in the forms in which use of force is reported

- observe deadlines for recording and reporting use of force

- consider drawing up written guidelines on prevention of violence and sexual abuse and the procedure for handling suspected abuse

- consider how its directions on the handling of medicines and on health matters can be made more practical to use for staff

- consider drawing up guidelines on prevention and handling of self-harm

'Specialindsats for Børn og Unge – Mellerup', Randers
Municipal residential institution for children and young people with, for instance, moderate or severe mental retardation or pervasive developmental disorders, milder or moderate developmental disorders within the autism spectrum and/or attention deficit disorders
In-house school
Talks with 8 users and 9 relatives etc.
DIGNITY participated

Recommendations
The visiting team recommended that 'Mellerup':

- continue endeavours to ensure that staff have an adequate knowledge of the rules on use of force of the legislation on adult responsibility for children and young persons in out-of-home care

- continue endeavours to prevent and reduce the incidence of use of force

- consider a staff training course on gentle grips in connection with use of force

- observe deadlines for recording and reporting use of force

- ensure an adequate description of the course of events (both before and during the incident) is provided in the forms in which use of force is reported

- consider drawing up written guidelines on prevention of violence and sexual abuse

- comply with the rules on teaching the full range of subjects and on the number of class hours per year

- comply with the rules on exemption from subjects and from compulsory national tests and lower secondary school examinations

'Handicapcenter Fyn – Børnehusene Stjernen', Odense
Regional residential institution for children and young people with substantially and permanently impaired mental and in many cases also physical functioning
Talks with 12 relatives etc.
DIGNITY and IMR participated

Recommendations
The visiting team recommended that 'Børnehusene Stjernen':

- ensure local additions to the regional guidelines on use of force are drawn up and that they state that it is the principal of the institution or the deputy for the principal who must record incidents involving use of force within 24 hours of the incident

- ensure the holders of parental responsibility – and to the extent possible also the children and young people themselves – are informed about their rights in relation to use of force and other restrictions on the right of self-determination, including about their right to complain,

on the children and young people's arrival, and that the local additions to the regional guidelines state that this must be done

- ensure reports on use of force include adequate information about the grounds for the use of force and management's assessment of the use of force

- ensure it is stated in reports on use of force that the holder of parental responsibility has been informed about the use of force

- observe deadlines for recording and reporting use of force

- ensure staff have a knowledge of signs of sexual abuse, and consider drawing up guidelines – perhaps in collaboration with the region – on the procedure for handling suspected sexual abuse

'Baunegård', Værløse
Municipal residential institution for children and young people with autism spectrum disorders and possibly additional diagnoses, such as learning difficulties or ADHD
Talks with 1[1] user and 7 relatives etc.
DIGNITY and IMR participated

Recommendations
The visiting team recommended that 'Baunegård':

- ensure all employees are aware that the Act on Adult Responsibility for Children and Young Persons in Out-of-Home Care is not applicable to young people in aftercare

- consider drawing up internal guidelines on use of physical force which explain, in an easy-to-understand way, the powers of staff in relation to use of physical force, including how they are permitted to use physical force

- be aware that the rule on self-defence does not authorise use of force but is a rule under which an act will under certain circumstances be exempt from prosecution

- complete drawing up written information material, in collaboration with the municipality, for both children and holders of parental responsibility about their rights in relation to use of force etc. to be given to them on the children's arrival

- use the form in the Executive Order on Adult Responsibility for Children and Young Persons in Out-of-Home Care for recording and reporting use of force

- ensure the times of recording and reporting entered in the forms in which use of force is reported are correct

- update the local sexuality policy to include, among other things, information about the physical and mental signs of which staff must be aware in relation to suspected sexual abuse

- ensure it is clear which set of directions on the handling of medicines is valid, and consider rewriting the comprehensive municipal directions into truly local directions based on local circumstances

- continue to consider how to ensure parents feel included and are given information about their children on a regular basis

'Fonden ConCura' – 'Opholdsstedet Bredmosegård' and 'ConCura Skolen'
Private accommodation facility for children and young people with impaired physical or mental functioning or psychiatric disorders
Daytime therapeutic facility with in-house school
Talks with 4 users and 8 relatives etc.
DIGNITY and IMR participated

Recommendations
The visiting team recommended that 'ConCura':

- consider a staff training course on the Act on Adult Responsibility for Children and Young Persons in Out-of-Home Care, including on gentle grips in connection with use of force

- update its guidelines on use of force to be geared specifically to the facility and to comply with the legislation on adult responsibility for children and young persons in out-of-home care

- ensure children, young people and holders of parental responsibility are informed about their rights in relation to use of force, including their right to complain, on the children and young people’s arrival

- ensure the times of recording and reporting entered in the forms in which use of force is reported are correct

- update its guidelines on prevention and handling of violence and sexual abuse to include information about the physical and mental signs

of which staff must be aware in relation to suspected sexual abuse and about the procedure for handling suspected abuse

- ensure the agreement on schooling is updated – in collaboration with the municipality of location – in line with the applicable rules

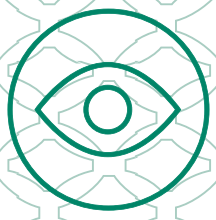
- ensure staff of the in-house school know which rules apply to use of force in the school

Foster family, Region of Southern Denmark
Specialised foster family
Talks with 3[2] users and 2 relatives etc.
DIGNITY participated

Recommendations
The visiting team recommended that the foster family:

- acquire knowledge of the rules of the Act on Adult Responsibility for Children and Young Persons in Out-of-Home Care, particularly the rules on physical guiding and on briefly holding or leading a person away when this is necessary to prevent substantial damage to property

1. A young person over the age of 18
2. Including one young person over the age of 18



Part Three

Thematic reports 2020

Thematic report 2020: Convicted persons with intellectual and developmental disabilities

Contents

1. What are the Ombudsman's general conclusions?

1.1. Introduction

Persons with intellectual and developmental disabilities who have committed a criminal offence are in many cases not given a prison sentence. Instead, they may be given a so-called preventive measures sentence ('foranstaltningsdom' in Danish).

The aim of a preventive measures sentence is to prevent further offences. Persons who are given a preventive measures sentence may among other things be placed in a social residential facility or in a secure unit. During the placement, socio-educational measures are implemented.

A preventive measures sentence is not a punishment but can none the less involve considerable restrictions being placed on the convicted persons. As an example, a number of the convicted persons can only leave the social residential facility or the secure unit if they have been given permission to do so. Some of the convicted persons may also have their access to internet or telephone restricted.

The sentences may have a duration of 3 or 5 years or may be of indefinite duration. The fixed-term sentences may be extended. The sentences must not be maintained for longer or more extensively than necessary, and can be terminated.

When assessing whether a preventive measures sentence should be modified or terminated, the risk of new offences must enter into the assessment.

The Ombudsman's monitoring visits to social residential facilities and secure units for adults in 2020 were especially focused on conditions for convicted persons with intellectual and developmental disabilities who had been placed in a social residential facility or a secure unit according to a preventive measures sentence.

1.2. General conclusions

In general, the Ombudsman finds that social residential facilities and the responsible ministries should strengthen general and individual crime prevention measures in relation to convicted persons with intellectual and developmental disabilities.

This is, among other things, because a risk of the convicted person committing further offences can affect how long a preventive measures sentence should remain in force. It may thus be important to the duration of the preventive measures sentence whether socio-educational initiatives have

been put in place with a focus on learning skills that will enable the convicted person to avoid committing new offences, and whether the result of these initiatives has been documented.

Consequently, there is a risk that there may be situations where it is necessary for the preventive measures sentence to remain in force for longer than would have been the case if a sufficient focus had been kept on the overall preventive measures. This risk occurs among other things when:

- the social residential facilities provide socio-educational initiatives without identifying the necessary crime prevention measures
- the social residential facilities do not document the result of crime prevention measures
- the social residential facilities do not know who the convicted person's guardian representative is and therefore do not provide the guardian representative with relevant information
- the convicted person does not have access to relevant addiction treatment.

The Ombudsman also points out that statistical data are lacking in this field. There is for instance no knowledge of the number of current preventive measures sentences or developments in the duration of the sentences.

In addition, the Ombudsman has seen examples of convicted persons being or having been unlawfully under 24-hour watch. The Ombudsman's monitoring activities have also shown that there is a risk of convicted persons being unlawfully restricted in, for instance, their access to the internet or in leaving the social residential facility when the facilities do not ensure that staff know the special provisions in that field or when the provisions or the interpretation of the rules are unclear.

2. What does the Ombudsman recommend?

In general, the Ombudsman recommends that social residential facilities receiving persons with intellectual or developmental disabilities who have been sentenced to preventive measures:

- focus on the crime-prevention purpose of the preventive measures sentence, including determine objectives for the crime prevention measures, and ensure documentation thereof when the municipality has asked the social residential facility to implement such measures

- ensure that the social residential facility knows who the convicted residents' guardian representatives are and provides the guardian

representatives with the information necessary for the guardian representatives to do their job

- ensure that staff know the rules regarding leave, and that an adequate note is made on how leaves are conducted, including leaves which have proceeded without any problems

- ensure that staff know the rules of the Social Services Act on the use of force and other restrictions, including the special rules in Chapter 24 d of the Act on enforcement of criminal sanctions etc.

- have clear guidelines on reporting to the police any incidents of violence and threats etc. between residents, and that residents are informed of the guidelines and informed that a report to the police of criminal offences may have a negative impact on the possibility of having a sentence modified or terminated

- establish guidelines for the prevention and handling of suicide, suicide attempts and self-harm if residents are at risk of this happening, and that the social residential facilities record and analyse such incidents.

The Ombudsman further recommends that, in connection with the up-coming review of the rules on allowing persons serving a preventive measures sentence to leave the social residential facility, the Ministry of Justice consider drafting a set of guidelines on the rules.

The Ombudsman will discuss the general conclusions and recommendations with the relevant ministries (the Ministry of Social Affairs and Senior Citizens and the Ministry of Justice).

In addition, the Ombudsman will discuss with the ministries how to ensure a more detailed statistical overview of the number of convicted persons with intellectual and developmental disabilities placed in a social residential facility according to a preventive measures sentence.

Such an overview would be of help to central authorities in the assessment of the need for a general initiative in this field, including for instance changes in the rules or the drafting of new methods which can be used in crime-prevention socio-educational initiatives. It would also – continuously – serve to provide an overview of the adequacy of the number of places in social residential facilities which can receive persons sentenced to preventive measures.

On 24 June 2021, the National Board of Social Services issued a news item on a study of addiction problems among adults with intellectual and

developmental disabilities. The study is part of a project where a prototype for a new treatment initiative will be developed. The Ombudsman will ask the National Board of Social Services to be informed of the result of the study and the new treatment initiative.

Furthermore, the Ombudsman will discuss with the Ministry of Social Affairs and Senior Citizens and Local Government Denmark the information on the municipalities' execution of the tasks in this field that the Ombudsman received in connection with the monitoring visits. In this respect, the Ombudsman will discuss with the Ministry and Local Government Denmark whether municipalities also need an increased focus on the crime-prevention purposes of preventive measures sentences. Among other things, most municipal action plans received by the Ombudsman from the visited places either did not contain objectives or initiatives with focus on crime prevention measures or they only contained very general targets for the initiatives.

Lastly, the Ombudsman will discuss the varying use of so-called consultation councils ('samråd' in Danish) with the Ministry of Social Affairs and Senior Citizens and the Ministry of Justice. Some municipalities use consultation councils, meaning a group of several experts in the field jointly carrying out a professional assessment of, for instance, recommendations for whether or not a sentence should be modified or terminated. Other municipalities carry out this assessment themselves.

On the Ombudsman's website is an overall list of the monitoring visits carried out in 2020 and the recommendations given during the visits. See en.ombudsmanden.dk/introduction/Monitoring_visits/monitoring_visits/adults_2020.

As part of the theme, the Ombudsman has investigated three general cases regarding the legal framework for convicted persons with intellectual and developmental disabilities. Two of the cases have been made public at the Ombudsman's website as FOB 2021-23 and FOB 2021-26 (in Danish only). There is a summary of the third case in Appendix 1.

3. What was the object of the Ombudsman's investigation?

The Ombudsman has investigated conditions for convicted persons with intellectual and developmental disabilities. In this report, the term 'intellectual and developmental disability' is used instead of 'mental retardation'.

What is an intellectual and developmental disability?

The WHO's International Classification of Diseases, ICD-10, defines mental retardation as: 'A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities.'

Source: WHO, ICD-10 Version: 2019

As mentioned, persons with intellectual and developmental disabilities who commit offences are in many instances not sentenced to imprisonment. They can instead be given a so-called preventive measures sentence. The aim of preventive measures sentences is to prevent further offences and may mean that the convicted person is placed at a general social residential facility or a secure unit. The placement can be of fixed or indefinite duration. Five types of preventive measures sentences are used. The court can, in addition, lay down terms for instance on the convicted person receiving treatment for any addictions.

The five types of preventive measures sentences

Type 1 – Sentence to placement in a secure unit for persons with extensive mental disabilities.

The convicted person is placed in a secure unit. In secure units, windows and outer doors are locked 24 hours or almost 24 hours a day. Normally, no maximum duration is stipulated in these cases. Currently, only the social residential facility Kofoedsminde has secure units.

Type 2 – Sentence to placement in a social residential facility for persons with extensive mental disabilities with the option of being transferred to a secure unit if the municipality finds this relevant.

The convicted person is placed in a social residential facility but the municipality can decide to transfer the convicted person to a secure unit without court approval. The sentence can be without maximum duration or for a maximum duration of five years.

Type 3 – Sentence to placement in a social residential facility for persons with extensive mental disabilities.

The convicted person is placed in a social residential facility. The sentence can be without maximum duration or for a maximum duration of five years.

Type 4 – Sentence to supervision by the municipality with the option of transferring to a social residential facility for persons with extensive mental disabilities.

As a starting point, the convicted person is only under supervision. However, the municipality can decide to place the convicted person in a social residential facility without court approval. The sentence can be without maximum duration or for a maximum duration of five years.

Type 5 – Sentence to municipal supervision so that the person with intellectual and developmental disabilities comply with the supervising authority's stipulations on residence and work.

The convicted person cannot be placed in a social residential facility pursuant to the sentence. The order is intended for persons with intellectual and developmental disabilities needing social support in everyday life. The supervision may be supplemented with special conditions. The sentence can have a duration of up to three years.

Source: The Director of Public Prosecutions' guidelines on mentally deviant criminals.

Fixed-term sentences can be extended. The sentences can, in addition, be modified or terminated. These decisions are made by the courts.

The investigation of the theme was limited to convicted persons with intellectual and development difficulties placed in a social residential facility or a secure unit in accordance with a type 1-3 sentence and convicted persons with a type 4 sentence where the municipality has decided that the convicted person must be placed in a social residential facility according to the sentence.

4. Why did the Ombudsman choose this theme?

The background for the Ombudsman choosing to investigate conditions for convicted persons with intellectual and developmental disabilities was the following:

- Convicted persons with intellectual and developmental disabilities constitute a vulnerable group and do not always understand their own rights or possibilities of complaint. Furthermore, as mentioned above, preventive measures sentences can be of an indefinite duration, and the convicted persons can be subject to the sentence for many years before it is terminated.

- Persons sentenced to preventive measures are subject to rules which allow the possibility of restrictions of basic rights. The rules are found in a number of laws and appurtenant executive orders. The overall responsibility for the field is divided between the Ministry of Justice and the Ministry of Social Affairs and Senior Citizens (including the National Social Services Board). The interpretation of the rules is not always clear.

- Conditions for the convicted persons are managed across a number of authorities etc., including

  - courts of law
  - the Director of Public Prosecutions and the various regional public prosecutors
  - municipalities
  - consultation councils
  - social residential facilities
  - guardian representatives
  - the National Knowledge and Specialist Consultancy Centre – VISO
  - the municipalities' addiction treatment programmes.

This target group is not in all instances part of the core activities area of the authorities etc. In many places, this target group is thus small and the cases few in relation to establishing routine procedures and identifiable practices in cases involving convicted persons with intellectual and developmental disabilities.

- There is no survey of the overall number of persons with intellectual and developmental disabilities who have been given a preventive measures sentence.

Appendix 2 shows an outline of some of the central rules and provisions concerning conditions for convicted persons with intellectual and developmental disabilities.

5. The Ombudsman's method

5.1. How was the investigation organised?

The theme was investigated through 17 monitoring visits to social residential facilities which receive convicted residents, including the secure units at the social residential facility Kofoedsminde. The 17 social residential facilities comprised seven facilities run by a municipality, six facilities run by a region (including the secure units at Kofoedsminde) and four privately run facilities. All visits were announced.

The monitoring visits were carried out as part of the Ombudsman's general monitoring activities pursuant to Section 18 of the Parliamentary Ombudsman Act and as part of the Ombudsman's task of preventing persons who are or who can be deprived of their liberty from being 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 to prevent degrading treatment etc. pursuant to the Protocol is carried out in cooperation with the Danish Institute for Human Rights and with DIGNITY – Danish Institute Against Torture. DIGNITY and the Institute for Human Rights contribute to the cooperation with, respectively, special medical and human rights expertise, among other things meaning that staff with expertise in these two fields participate on behalf of the two institutes in the planning and execution of and follow-up on monitoring visits.

As part of the preparations for the investigation, the Ombudsman had meetings with the Consultation Council for Offenders with Intellectual and Developmental Disabilities in the Region of Southern Denmark (*Samrådet for*

udviklingshæmmede lovovertrædere i Region Syddanmark), the East Jutland Consultation Council in Aarhus Municipality (*Det Østjyske Samråd i Aarhus Kommune*), a privately run social residential facility, a representative for the National Association for People with Intellectual and Developmental Disabilities (*Landsforeningen LEV*), a representative for the Public Prosecutor of Copenhagen and with two representatives for the National Association of Patient Advisors and Guardian Representatives in Denmark (*Landsforeningen af Patientrådgivere og Bistandsværger i Danmark*). The purpose of the meetings was to gather background information about conditions in the field.

As part of the theme, the Ombudsman chose to initiate three general own-initiative investigations to clarify the interpretation of the rules in the field. Two of the cases have been made public at the Ombudsman's website as FOB 2021-23 and FOB 2021-26 (in Danish only). There is a summary of the third case in Appendix 1.

5.2. What did the Ombudsman investigate?
The following was investigated under the year's theme:

- Are efforts being made to ensure that residents are no longer at risk of committing offences, and is enough done to document these efforts (item 6.1.2 and 6.1.3)?

- Do the municipality and the social residential facility observe the rules when making decisions on applications for leave (item 6.2)?

- Do residents have access to relevant addiction treatment and sexological treatment or sex education (item 6.3)?

- Does the social residential facility observe the special rules on use of force and other restrictions against convicted residents (item 6.4)?

- Is there a risk of conditions having a knock-on effect (item 6.5)?

- Does the social residential facility prevent violence and threats between residents (item 6.6)?

- Do residents have access to relevant health service treatment (item 6.7)?

- Is there a focus on prevention of suicide and self-harm (item 6.8)?

5.3. How were conditions investigated during the monitoring visits?
Prior to the individual monitoring visit, the latest supervisory report and any supplementary data from the local social supervisory authority were obtained.

In addition, the Ombudsman obtained any supervisory reports from for instance the Danish Patient Safety Authority and any decisions etc. from the Danish Working Environment Authority.

In the opening letter for the individual monitoring visit, management was asked for information on a number of factors and for copies of the material on the subject. This concerned information on residents' preventive measures sentences, municipal action plans and the social residential facility's educational plans, leave permissions and leave protocols.

During the monitoring visits, management, staff and to the widest possible extent residents, guardian representatives, guardians and relatives were interviewed about conditions for the residents, including in particular convicted residents placed in the social residential facility.

6. What did the Ombudsman find?

6.1. Is there a focus on crime prevention measures?

6.1.1. Is there a duty to implement crime prevention measures?
As mentioned under item 1 above, the purpose of preventive measures sentences is to prevent further offences. A preventive measures sentence is not a punishment but it can still result in considerable restrictions for the convicted persons. By way of example, a preventive measures sentence can mean that convicted persons are placed in a social residential facility or a secure unit, and some of the convicted persons may only leave the social residential facility or the secure unit if given permission to do so. Convicted persons may also be restricted in their access to the internet or telephones.

The public prosecutor monitors that preventive measures sentences do not remain in force for longer and more extensively than necessary. The public prosecutor has a duty to bring such questions before the courts, which then make decisions on whether or not to change or terminate preventive measures sentences. Such questions can also be brought before the courts at the request of the convicted person or the guardian representative.

In the assessment of whether or not a preventive measures sentence should be modified or terminated, the risk of new offences (including the nature and gravity of the offences) and the character and duration of the preventive measures sentence are among the factors that are taken into account. The potential risk of the convicted person committing further offences therefore affects how long a sentence remains in force. It can thus affect the duration of a preventive measures sentence that socio-educational initiatives are

implemented, with a focus on achieving skills so that the convicted person can avoid committing new offences.

For use in the assessment, the public prosecutors obtain statements from the social residential facility, the municipality and the so-called consultation councils. The public prosecutors do not, however, instruct municipalities and social residential facilities in what kind of socio-educational initiatives they should implement.

The municipalities have a duty to receive persons with a preventive measures sentence in social residential facilities. Pursuant to the Act on Due Process, municipalities must also carry out a special crime prevention supervision. In a case raised by the Ombudsman in connection with the theme, the Ombudsman could not disregard the opinion of the Ministry of Social Affairs and Senior Citizens that the duty to carry out crime prevention supervision pursuant to Section 16 a of the Act on Due Process only occurs when it has been decided specifically by judgment or sentence etc. that a person shall be subject to supervision by the social authorities. In practice, this means that, according to this provision, the supervisory duty does not include persons who are deprived of liberty due to having been sentenced to placement in an institution (type 1-3 sentences).

Furthermore, in the same case the Ombudsman did not overall have a basis for disregarding the opinion of the Ministry of Social Affairs and Senior Citizens, according to which the provision on crime prevention supervision does not obligate municipalities to implement, as part of the supervision, crime prevention measures towards those persons who are within the scope of this provision.

However, he did point out that several matters could give reason to suppose that, according to circumstances, there can be a duty to implement crime prevention measures. Among other things, he pointed out that it is specified in the National Board of Social Services' handbook, 'Handbook on charged and convicted citizens with intellectual and developmental disabilities – Statutory provisions and crime prevention measures' that the municipalities may have a duty to implement crime prevention measures. He also pointed out that in the guidelines of the Ministry for Children and Social Affairs on legal rights and administration in the social field, it is cited that municipal implementation of the criminal sentence makes relevant, and must take into account, an assessment of the citizen's need for aid and support pursuant to the Act on Social Services.

In connection with the case, the Ministry of Social Affairs and Senior Citizens stated that, according to the Act on Social Services, the municipalities have a duty to implement measures which are suitable for the individual citizen, and

that the supervision and duty to act can, according to circumstances, mean that the municipal council must implement socio-educational initiatives pursuant to the Act on Social Services which can also have a crime-preventing effect. The municipality will also have to implement measures based on conditions in the sentence which fall within the Act on Social Services or other relevant legislation.

The Ombudsman informed the Ministry of Social Affairs and Senior Citizens, the Folketing's Legal Affairs Committee and the Folketing's Social Affairs and Senior Citizens' Committee of his assessment of the case. See the Ombudsman's statement in the case FOB 2021-23 (in Danish only) at the Ombudsman's website.

It appears from several judgments from the European Court of Human Rights that there may be a duty to implement crime prevention measures towards some persons deprived of their liberty. The Ombudsman is not aware of any judgments where the Court has taken a position on the Danish system regarding persons with intellectual and developmental disabilities being sentenced to preventive measures.

6.1.2. Are crime prevention measures implemented in practice, and are there targets for the measures?

During the monitoring visits, it was investigated whether the social residential facilities had a focus on implementing crime prevention measures towards the convicted person.

Targets for social work

Clear and relevant targets are crucial to the quality and effect of practice. When clear targets are formulated, transparency and systematism in the initiatives are achieved together with agreement on what to aim for.

Source: 2016 publication from the National Board of Social Affairs and the National Research and Development Centre for Welfare and Health (SFI), 'Lovende praksis på det specialiserede socialområde' (Promising practice in the specialised social field).

Three examples of the municipalities' action plans and the social residential facility's educational plans or similar material were collected prior to each monitoring visit.

The purpose of a municipal action plan is to clarify the target for the initiatives, to secure a cohesive and systemic effort, and to clarify the duty of all persons, agencies and administrative branches. Among other things, an

action plan must indicate what measures are necessary in order to reach the target.

In the investigation which the Ombudsman raised on his own initiative towards the Ministry of Social Affairs and Senior Citizens as part of the theme, cf. item 6.1.1 above, the Ministry has stated that the municipalities do not generally have a direct duty to draw up an action plan for convicted persons with intellectual and developmental disabilities. The direct duty to do so occurs when force is used against the citizen. See the statement in the case on FOB 2021-23 (in Danish only) at the Ombudsman's website.

The social residential facilities will often draw up an educational plan or something similar which contains targets for the specific measure(s) which must be implemented at the facility.

The monitoring teams examined whether crime prevention targets and initiatives had been selected for persons with preventive measures sentences in the municipalities' action plans and the social residential facilities' educational plans.

In municipal action plans received from two of the visited facilities, there was a focus on crime prevention measures. The plans contained examples of specific measures which in the municipality's assessment were necessary. In addition, there was one facility where there generally were no crime prevention targets and initiatives in the received municipal action plans but where a target was indicated in the action plan of one resident where the most obvious reason for it would have to be that it had a crime-preventive aim.

The municipal action plans received from the other 14 visited facilities either did not contain targets or initiatives with focus on crime prevention measures or contained only very general targets for the initiatives. Out of these 14 places, 13 social residential facilities had not in their educational plans etc. expressly identified what targets or initiatives were necessary for crime prevention measures.

There were, in addition, four social residential facilities which did not receive information regarding the residents' sentences or which had to obtain the information themselves. It is of course important that social residential facilities are aware of any sentencing conditions such as for instance addiction treatment or other crucial information of importance to the relevant measures, for instance the type of crime committed. On that basis, one social residential facility management was recommended to ensure that the facility had the necessary information on what residents had been convicted for and the conditions for placement at the facility.

The visiting teams discussed these issues with management at the social residential facilities they visited. Often, management and staff stated that the overall socio-educational initiatives constituted the crime prevention measures. For instance, one social residential facility stated that all of the socio-educational initiatives towards one particular resident were about preventing the resident from hitting. Another social residential facility sought to ensure structure for a resident to prevent new offences being committed. It was also stated, however, that there cannot be an expectation in all cases that the socio-educational initiatives can result in a permanent improvement of the convicted person's behaviour.

Typically, however, managements of social residential facilities could see the benefit of determining what conditions it would be especially necessary to work on in order to stop the person in question from committing offences, and to document developments within these targets.

The visiting teams did not recommend to social residential facility managements to ensure a focus on crime prevention measures when no targets for crime prevention measures had been set in the municipal action plans. This is because social residential facilities do not have an independent legal duty to implement crime prevention measures.

However, it was pointed out as a focus point in six of these facilities to document targets for crime prevention work in the educational plans.

In addition, in one case management was recommended to ensure that sub-targets and initiatives necessary to and part of crime prevention measures be described in the social residential facility's implementation of crime prevention targets in the municipal action plans for residents. Only very general crime prevention targets were indicated in the municipality's action plans but the municipality and the social residential facility had agreed that the facility would implement the general targets in concrete crime prevention measures.

In regard to another facility, an own-initiative case was raised with the municipality, as the overall socio-educational and treatment initiatives seemed inadequate. The convicted person was transferred to another institution, and the Ombudsman closed the case without giving a statement.

In a third facility, management was recommended to ensure that measures be implemented in relation to residents who do not observe the rules for their leaves, and that these measures are documented.

A fourth facility was recommended that the facility seek professional assistance in relation to a specific resident with a view to ensuring an acceptable and non-transgressive behaviour with regard to sex, and that the facility in this connection set up educational targets and initiatives necessary to the crime prevention measures.

The Ombudsman does not have the socio-educational qualifications to make a detailed assessment of socio-educational initiatives, including whether the initiatives can have a crime-preventive effect. However, it is the Ombudsman's impression that initiatives were generally implemented with a view to helping residents with their basic challenges.

In this context and based on information from the social residential facilities, the Ombudsman takes into account that the implemented socio-educational initiatives can also have a crime-preventive effect. However, it had far from always been identified which specific socio-educational targets to achieve in order to prevent new offences from being committed. This may carry a risk that there is insufficient focus on the overall preventive measures and thereby means that preventive measures sentences have to remain in force.

The information forms part of the basis for the general recommendation that social residential facilities receiving persons with intellectual and developmental disabilities, who have been given a preventive measures sentence, maintain a focus on the crime-preventive purpose of the preventive measures sentence, including determining targets for the crime prevention measures and ensure documentation of the results thereof when the municipality has asked the facility to implement such measures.

6.1.3. Are the measures and their results documented?

Documentation of the results of the socio-educational initiatives

Good documentation and evaluation contribute to giving the citizen the best possible (socio-educational) assistance.

Source: The National Board of Social Affairs' handbook 'Håndbog for socialtilbud – Resultatdokumentation og evaluering' (Handbook for social services – Documentation and evaluation of results. In Danish only).

A number of social residential facilities said that they had not been instructed in what was necessary to document in statements to the public prosecutors on maintaining etc. preventive measures sentences. Nor were the facilities always briefed on the contents of the authorities' or consultation councils' statements to the public prosecutors. These social residential facilities

therefore had no certain knowledge of what is taken into account when assessing whether a preventive measures sentence can be modified or not.

In practice, documentation was typically done in journals or daily logs. At several facilities, it was possible to use bookmarks so that documentation on the individual target or measure could be retrieved. Since, as mentioned above under point 6.1.2, in many cases no identification had been made of what targets and initiatives were necessary in order to prevent further offences being committed, there was for that reason in many places no possibility of documenting the initiatives within targets that related to crime prevention measures, either.

The visiting teams did not give recommendations on documenting crime prevention measures if there were no targets for crime prevention measures in the municipalities' action plans. This is because social residential facilities do not have an independent legal duty to initiate crime prevention measures.

One recommendation was given on documentation of the initiatives towards a particular resident. Furthermore, in three places it was selected as a special attention point to increase the focus on documenting crime prevention measures – and the results thereof. In addition, several social residential facilities would, in continuation of the monitoring visit, consider starting to indicate targets and initiatives or otherwise link documentation of targets, initiatives and results.

In addition to the importance for the quality of the initiatives, documentation of the initiatives and the results thereof are also important to social residential facilities being able to deliver a true and adequate description of the resident's progress. Thus, a well-documented description can be essential when decisions are to be made on leave or statements are to be given for use in the public prosecutor's supervision of preventive measures sentences not remaining in force for longer than necessary. When making these assessments, the risk of the convicted person committing new offences is among the things taken into account.

The data form part of the basis for the general recommendation that social residential facilities receiving persons with intellectual and developmental disabilities who have been sentenced to preventive measures have a focus on the crime-prevention purpose of the preventive measures sentence, including laying down targets for the crime prevention measures and ensure documentation of the results thereof when the municipality has asked the social residential facility to implement such initiatives.

6.1.4. Guardian representatives

A guardian representative must be appointed for persons with a preventive measures sentence. The guardian representative must keep informed of the convicted person's condition and ensure that the stay at the social residential facility and other measures do not extend longer than necessary. The guardian representative can request that issues on changing or rescinding the preventive measures sentence be brought before the courts.

The social residential facility has a duty to inform the guardian representative of the placement and must furthermore provide the guardian representative with any information necessary for the guardian representative to carry out the duty in a responsible manner.

In five out of 17 social residential facilities, the Ombudsman has recommended that management identify the residents' guardian representatives so that the facility can observe its notification duty in relation to the guardian representatives. In two facilities, management was advised on the facility's notification duty towards the guardian representatives. In one facility, management was recommended to change internal guidelines so that the facility's duty to notify the guardian representative appeared, and in another facility, management was recommended to ensure that the facility provide the guardian representative with the necessary information.

The Ombudsman recommends in general that social residential facilities receiving persons with intellectual and developmental disabilities who have been sentenced to preventive measures ensure that the facility knows who the convicted residents' guardian representatives are, and provides the guardian representatives with the information necessary for the guardian representatives to carry out their task.

6.2. Are the rules on leave observed?

Convicted residents with type 1-3 sentences are not allowed to leave the social residential facility without permission. There are rules on permissions for leave in the so-called Leave Order (Executive Order on Leave for inmates serving a sentence of imprisonment or safe custody). The authority to make this decision is (generally) distributed between the municipalities and the local public prosecutors. The decisions of the local public prosecutors can be appealed to the Director of Public Prosecutions. It is not possible to appeal the municipalities' decisions on leave.

As part of the theme of convicted persons with intellectual and developmental disabilities, the Ombudsman has carried out a general own-initiative investigation of the rules on leave permissions, as the rules have given rise to considerable doubt and varied practices. The Ombudsman raised a number of questions concerning understanding of the relevant rules, including

questions regarding authority. This has brought about a clarification of, especially, questions of who has the authority to make decisions on leave.

The Ombudsman has brought to the Ministry of Justice's attention that the applicable rules in the Leave Order may result in some practical challenges, for instance:

- when the municipality or the social residential facility principal cannot make a decision on leave for urgent admission to a psychiatric hospital

- when social residential facilities, which have not been entrusted with the authority to make decision on leave, cannot make a decision on leave for emergency admissions to a somatic hospital.

The Ministry of Justice has stated that the Ministry in the next parliamentary session will institute a revision of the rules on leave. In this connection, the Ministry has indicated that statutory authority should be provided so that the authority to make decisions on leave in certain instances can be left to the facility management, including regional and private facilities.

Please see the summary of the Ombudsman's statement in Appendix 1.

It is important that the social residential facilities and the municipalities are familiar with the rules on leave and the interpretation of these rules. Among other things, this is because leave constitutes a modification of the placement sentence, as the resident, for a temporary period, does not have a duty to remain at the facility. In addition, leaves are often a part of the socio-educational initiatives which are meant to ensure that the convicted person can be a part of the surrounding community without being at risk of committing new offences. The leaves are thus an important element in the overall crime prevention measures which social residential facilities deliver.

On that background, among other things, it is important to carry out a true documentation of how leaves have proceeded, including whether they have proceeded without any problems. Information in this regard may enter into the assessment of later applications for leave and in the assessment by the public prosecutors and courts of whether to maintain the preventive measures sentence.

Some social residential facilities said that there were differences in the way municipalities interpret the rules in the Leave Order. There may also be differences of interpretation within the individual municipality. During the visits, the Ombudsman learned of several examples of various cases of doubt and variation in practice:

- One municipality demanded that applications for leave were sent 30 days before the requested leave from the social residential facility. In other places, a decision was made shortly before or on the same day that the leave was to be held.

- One social residential facility had the impression that the region – not the municipality – could make a decision on permission to leave the facility.

- There was doubt as to when the municipalities could give a convicted person permission for many leaves at once, and when a new decision had to be made on each individual leave.

In the final analysis, the varied practice can have a bearing on whether or not a preventive measures sentence remains in force, as the convicted person during leaves will have the possibility of practising and showing that the person can cope outside the setting of the social residential facility.

One social residential facility stated that the local social supervisory authority and the public prosecutor had varying opinions of the facility's authority to make decisions on permissions for leave, and that this had complicated a clarification of whether it was the facility or the public prosecutor who should make the decision.

In two instances, the Ombudsman gave recommendations with the purpose of ensuring that staff were familiar with the rules in the Leave Order. In addition, in 12 instances management was informed of the Ombudsman's general case regarding the Leave Order. Because of the general case, a number of questions regarding the Leave Order were not investigated in relation to the individual social residential facility. The Ombudsman has informed the Ministry of Justice of examples where there is in practice doubt regarding the way in which the Leave Order is to be interpreted, or where it present challenges.

Leaves were typically documented in a special log or in records. In a few places, leaves were documented in diaries or journals – often with the possibility of 'tagging' the information under the subject 'leave'.

In six places it was pointed out as a focal point or recommended to management to ensure that the social residential facility carry out adequate documentation of leaves. There could for instance be a lack of information on the leave having proceeded without problems.

As mentioned above, during the monitoring visits the Ombudsman has seen examples of a varied practice and doubt as to the interpretation of the rules on permissions for leave on the part of municipalities and social residential

facilities. As mentioned, it is not possible to appeal the municipalities' decisions. Therefore, there is no possibility of ensuring a uniform practice via a central complaint body. At the same time, there is no guidance on how to interpret the relevant rules.

The Ombudsman recommends that in connection with the forthcoming amendment of the rules on permission for persons with a preventive measures sentence to leave the social residential facility, the Ministry of Justice consider drafting adequate guidelines on the rules.

The Ombudsman recommends in general that social residential facilities receiving persons with intellectual and developmental disabilities and a preventive measures sentence ensure that staff are familiar with the rules on leave and that an adequate record is written on the conduct of leaves, including leaves which have proceeded without problems.

Furthermore, the Ombudsman's observations under this point are included in the basis for the recommendation that social residential facilities receiving persons with intellectual and developmental disabilities and preventive measures sentences have a focus on the crime-prevention purpose of the preventive measures sentences, including determining targets for the crime prevention measures and ensure documentation of the results thereof when the municipality has asked the facility to implement such measures.

6.3. Is there access to addiction treatment and sexological treatment or sex education?

6.3.1. Addiction treatment

Alcohol and drug abuse are risk factors in relation to criminal behaviour in convicted persons with intellectual and developmental disabilities.

Source: The National Board of Social Affairs' handbook 'Håndbog om domfældte og sigtede udviklingshæmmede' (Handbook on convicted and charged persons with intellectual and developmental disabilities. In Danish only)

During several of the monitoring visits, the social residential facilities pointed out that several of the convicted persons with intellectual and developmental disabilities had substance abuse problems.

This may influence the possibility of having a preventive measures sentence modified or terminated if the convicted person is helped out of any substance abuse. This is because of a possible connection between the convicted person's substance abuse and the risk of further criminal behaviour. In some

cases conditions on substance abuse treatment are laid down in the preventive measures sentence.

During six monitoring visits, management said that it is difficult to find suitable municipal services on treatment of substance abuse which are targeted at persons with a cognitive function impairment. The social residential facilities also asked for guidance on how to handle convicted persons who do not voluntarily seek substance abuse treatment.

Some social residential facilities said that they tried to help residents with substance abuse problems through general pedagogical measures. Other facilities said that they used a special method for this which takes into account the level of cognitive function. One facility used VISO (the National Knowledge and Specialist Consultancy Centre).

During the monitoring visits, information on substance abuse and treatment of substance abuse gave rise to the following recommendations etc.:

- The Ombudsman raised an own-initiative case towards a municipality concerning measures for a resident where the treatment needs against substance abuse were not met. The resident was transferred to another institution, and the Ombudsman closed the case without a statement.

- There was a risk at one social residential facility that residents resumed previous substance abuse or started substance abuse because for instance other residents were substance abusers. The Ombudsman recommended to the facility's management to ensure that the pedagogical treatment had an increased focus on preventing substance abuse.

- At another social residential facility, there was widespread substance abuse among residents. The facility's management was recommended to ensure that staff know how to handle the situation when a resident returns to the facility intoxicated by alcohol or drugs after being on leave. Management was also encouraged to seek information on how to handle substance abuse.

- At one social residential facility, management was recommended to ensure that a clear understanding is established among staff on how to handle problems related to cannabis dealing.

Information on substance abuse and substance abuse treatment is included in the basis for the Ombudsman's general recommendation that social residential facilities receiving persons with intellectual and developmental disabilities and a preventive measures sentence focus on the crime-prevention purpose of preventive measures sentences, including determining

targets for the crime prevention measures and ensure documentation of the results thereof when the municipality has asked the facility to implement such measures.

On 24 June 2021, the National Board of Social Affairs published news of a study of substance abuse problems among adults with intellectual and developmental disabilities. The study is part of a project in which a prototype for a new treatment initiative will be developed.

The Ombudsman will ask the National Board of Social Affairs to be informed of the result of the study and the new treatment initiative.

6.3.2. Sexological treatment or sex education
Some of the convicted persons with intellectual and developmental disabilities are convicted of offences involving sexual abuse.

Generally, convicted persons had access to either sexological treatment in a psychiatric setting, including with the oligophrenia team (specialists in psychiatric patients with intellectual and developmental disabilities), special VISO courses or sex education at the social residential facilities. Therefore, conditions did not give the monitoring teams cause to make any recommendations.

Information on a lack of initiatives towards convicted persons with an inappropriate behaviour gave cause for the following recommendations etc.:

- In respect of one particular resident, one social residential facility was recommended to seek professional assistance with a view to ensuring an acceptable and non-transgressive sexual behaviour.

- Another social residential facility described how a resident stated that he was sexually attracted to children. The Ombudsman raised an own-initiative case towards the municipality concerning measures for the resident. The resident was transferred to another institution, and the Ombudsman closed the case without a statement.

6.4. Are force and other restrictions carried out in accordance with the applicable rules?
Chapter 24 of the Social Services Act contains rules detailing the kind of restrictive measures that can be used without consent against persons with a substantial and permanent impairment of mental function who, pursuant to Social Services Act rules, are receiving personal and practical help or socio-education assistance etc., treatment or offers of activation. The restrictions may be for instance use of physical force in connection with restraining the person. A number of the rules were amended on 1 January 2020. The

general rules on use of force according to Chapter 24 of the Social Services Act apply, regardless of whether the resident has received a preventive measures sentence.

In addition, Chapter 24 d of the Social Services Act contains special rules on the enforcement of criminal sanctions etc. which allow restrictions against convicted persons who have been placed in a social residential facility in accordance with a preventive measures sentence. There is for instance authority to restrict the convicted person's access to telephone and internet, to examine the convicted person's housing unit and to lock the convicted person's housing unit for the night.

Restrictions pursuant to the special rules on the enforcement of criminal sanctions etc. are carried out according to the municipality's decision thereon. However, the social residential facility's principal may in urgent cases make a provisional decision, which will subsequently have to be submitted to the municipal council for approval.

There is a right to complain about both restrictions according to the general rules on the use of force and restrictions according to the special rules on the enforcement of criminal sanctions etc. In some cases, a complaint can be submitted to the municipal council, and in other cases, a complaint can be submitted to the National Social Appeals Board. Restrictions involving a deprivation of liberty can be brought before the courts. The restrictions must be registered and reported to the municipality, among others. The convicted person will then have the opportunity to make a statement on the matter.

If staff do not know the legal scope for the use of force and other restrictions, there is a risk that unlawful restrictions will be carried out – perhaps without the resident being advised of the possibility of complaining about the restriction. There can for instance be a risk that staff restrict a resident's access to the internet without a prior decision from the municipality and without the resident being advised of the possibility of submitting a complaint about the restriction. There may also be a risk of staff using physical force without the conditions in this respect being met.

The Ombudsman recommended to four social residential facilities to update local guidelines and instructions regarding the use of force in accordance with applicable rules.

The Ombudsman also gave recommendations to three social residential facilities to ensure that staff were familiar with the rules on restrictions in accordance with the special rules on enforcement of criminal sanctions. One facility was advised that the planned restrictions of a resident's access to the

internet could be subject to the special rules on enforcement of criminal sanctions, etc.

In general, the social residential facilities were focused on advising residents of the possibility of complaining about the use of force or other restrictions. However, at one facility, management was recommended to draw up guidelines for the use of force. In this connection, it was taken into account that two residents had said that they had not been advised of the possibility of complaining. At another facility, it was pointed out as a special attention point to ensure that debriefings were held, as it was part of the debriefings to advise residents that they could complain about a use of force. At two facilities, management was recommended to update local guidelines and instructions regarding the use of force in accordance with applicable rules, including applicable rules for guidance on complaint.

Three social residential facilities pointed to a dilemma in a new rule in the Social Services Act that the facility's staff principal must regularly inform relatives, representatives with lasting power of attorney, guardians or other representatives of any restrictions carried out against a resident. The rule is absolute and established to ensure that residents unable to complain themselves about restrictions can receive assistance to do so. However, the facilities stated that residents are not always interested in relatives etc. being informed.

Five social residential facilities stated that they monitored or had monitored convicted residents round the clock. In one facility, this could for instance be carried out by staff either entering or letting themselves into the resident's housing unit or by the resident sleeping with the curtains drawn back so that staff could see the resident.

As part of the theme, the Ombudsman raised a case with the Ministry of Social Affairs and Senior Citizens regarding round-the-clock monitoring of convicted persons with type 2-4 sentences. The Ombudsman agreed with the Ministry that there is no authority for a social residential facility, in order to prevent escape in general, to monitor residents in areas at the sole disposal of the individual resident by gaining access to the resident's housing unit without consent or to demand that the resident makes it possible for staff to look into the housing unit from the outside.

The Ombudsman has recommended to the Ministry to ensure that the social residential facilities are made aware that they do not have the authority to thus monitor without consent residents placed in the facility in accordance with a sentence in areas which are at the sole disposal of the individual resident, unless a decision has been made of locking up a resident according to the Social Services Act in order to prevent escape.

See the statement in the case on FOB 2021-26 (in Danish only) at the Ombudsman's website.

The Ombudsman recommends in general that social residential facilities receiving persons with intellectual and developmental disabilities and a preventive measures sentence ensure that staff are familiar with the rules in the Social Services Act on the use of force and other restrictions, including the special rules in Chapter 24 d of the Act on enforcement of criminal sanctions, etc.

6.5. Is there a risk of conditions having a knock-on effect?
The majority of convicted persons with intellectual and developmental disabilities who are placed in a social residential facility according to a sentence are placed at a general facility with non-convicted residents.

Several of the visited social residential facilities had residents placed in accordance with a sentence and persons who had been referred to a place at the facility according to the general rules of the Social Services Act.

During the monitoring visits, the Ombudsman did not receive any information of instances where the special rules applicable to convicted persons placed at a social residential facility in accordance with a sentence were used towards non-convicted persons. See item 6.2 on the rules in the Leave Order and item 6.4 on the rules in the Social Services Act on enforcement of criminal sanctions, etc.

Consequently, the monitoring teams did not give any recommendation regarding this issue.

6.6. Do the social residential facilities prevent violence and threats between residents?
All 17 social residential facilities had a focus on preventing violence and threats between residents. The preventive measure is often individually planned and a part of the overall pedagogical measures.

In one case, the Ombudsman recommended drafting an anti-violence policy with a view to prevention, as there could be a risk that staff did not have a uniform approach to prevention of violence and threats.

In four cases, the Ombudsman recommended that guidelines be established for registering violence and threats between residents. The registration enables social residential facilities to follow developments and analyse when and towards whom violence and threats are made. This will also give facilities a better chance of preventing further episodes of violence and threats.

In eight cases, the Ombudsman recommended or urged management to ensure the establishment of a policy, or the adjustment of a policy already in place, on reporting violence and threats etc. to the police. This includes setting guidelines for what to report and who has responsibility for making the report.

In 12 instances, management was recommended or urged to ensure that residents are made aware of the social residential facility's policy on reporting to the police, and in 12 instances, management was recommended or urged to ensure that the resident is informed that a report to the police of criminal offences may have a negative impact on the possibility of having a sentence modified or terminated.

The Ombudsman recommends in general that social residential facilities receiving convicted persons with intellectual and developmental disabilities and criminal measures sentences have clear guidelines for reporting to the police violence and threats etc. between residents, and that residents are informed of the guidelines and of the fact that a report to the police of criminal offences may have a negative impact on the possibility of having a sentence modified or terminated.

6.7. Do residents have access to relevant healthcare services?
Whether residents receive relevant healthcare treatment can depend on healthcare staff understanding the special needs which persons with intellectual and developmental disabilities may have.

Most social residential facilities described access to a general medical practitioner and hospital treatment, including psychiatric wards, as well-functioning. Therefore, the visiting teams did not give any recommendations in this regard.

However, two social residential facilities experienced among healthcare staff a varying understanding of the special needs which persons with intellectual and developmental disabilities may have. There can for instance be challenges involved in waiting in a crowded waiting room, not having a permanent general medical practitioner or in attending blood sample appointments. There may also be challenges in relation to having residents fully assessed if healthcare staff do not have a sufficient knowledge of the target group.

Other social residential facilities had a close cooperation with for instance the residents' general medical practitioners and psychiatric wards. One facility stated for instance that residents can go in through the back door so they avoid waiting in the waiting room. In another facility, the psychiatrist visited the facility.

In one case, there were great challenges in getting a resident assessed at the psychiatric ward because the resident also had an addiction. Some of the social residential facilities also experienced that residents were being discharged too quickly from the psychiatric ward, and without a clear action plan.

6.8. Is there a focus on prevention of suicide and self-harm?
In 13 of the visited social residential facilities, there were residents who were to a minor or major extent at risk of self-harming or attempting suicide. This risk was dealt with through pedagogical methods, supervision and through cooperation with the psychiatric sector or VISO.

It can be critical for the life and health of residents that staff, including temporary staff, know what they can do to prevent and handle suicide, suicide attempts and self-harm.

In six instances, management was recommended or urged to ensure that guidelines are established for how suicide, suicide attempts and self-harm are prevented and handled and how the causes of the incidents are analysed.

Guidelines for prevention and handling of suicide attempts etc. will also be able to support that staff have the necessary knowledge, and will therefore also be able to support the prevention of such incidents.

Another tool for preventing suicide and self-harm is registration and analysis of such incidents. A recommendation to do so was given in four cases.

The Ombudsman recommends in general that social residential facilities establish guidelines for prevention and handling of suicides, suicide attempts and self-harm if there is a risk of this among residents, and that the facilities register and analyse such incidents.

6.9. Statistical overview of the population
Statistics Denmark and the Ministry of Justice's Research Office make a survey of the number of new preventive measures sentences every year.

The preventive measures sentences in the Ministry of Justice's survey include both sentences for treatment and hospitalisation in the psychiatric sector and the type 1-5 sentences described under item 3. The number of new type 1-5 sentences is thus included in the survey's data but it is not possible to see how large a percentage of the overall number of preventive measures sentences that type 1-5 sentences constitute. Every year in the years 2015 till 2019, between 771 and 835 new preventive measures

sentences were passed. Of these, between 39.9 and 43.6 per cent of the sentences were of indefinite duration.

The survey solely concerns new preventive measures sentences and does not contain information on the number of current sentences where the convicted person is still subject to the preventive measure sentence or information on the average duration of the sentences.

The municipalities made a survey in 2019 and 2020 of the number of convicted persons with type 1 and type 2 sentences. The municipal survey was carried out among other things to uncover whether there are a sufficient number of places in secure units.

So there is no information on the number of current type 1-5 sentences and the duration thereof spread out over the individual types of sentences. Such information would have given an overview of whether the number of current sentences is rising or falling and whether there is any development in the longer or shorter duration of sentences. Such an overview would be of help to central authorities in the assessment of a possible need for a general initiative in the field, including for instance amendments of the rules or the drafting of new methods which can be used in crime-preventive, socio-educational initiatives. It would also – on a continuous basis – give an overview of the adequacy of the number of places at social residential facilities which can receive persons sentenced to preventive measures.

The Ombudsman will discuss with the Ministry of Justice and the Ministry of Social Affairs and Senior Citizens how to ensure a more detailed statistical overview of the total number of convicted persons with intellectual and developmental disabilities placed in a social residential facility pursuant to a preventive measures sentence spread out on the individual sentence types, including statistics on the average duration of the sentences, thus making it possible to get an overview of the population and developments therein.

6.10. Municipalities and consultation councils

Generally, it is the municipality which monitors and makes decisions about persons with a preventive measures sentence. In practice, however, in a number of cases it was the social residential facility which made decisions on leave, and in some cases the execution of the monitoring tasks was left to the social residential facility or other authorities.

Some municipalities have entered into agreements on the establishment of so-called consultation councils. There are no statutory rules on consultation councils but the use of consultation councils typically means that a number of experts together take part in carrying out a professional assessment of for instance the recommendation on whether or not a sentence should be

modified or remain in force. In other places, it is the municipality itself which carries out this assessment. The assessment is used by the prosecution service and the courts.

The Ombudsman's investigation did not include the consultation councils or the municipal processing of the cases on placement of and socio-educational support to convicted persons with intellectual and developmental disabilities.

As part of the investigation, the Ombudsman has, however, received data which indicate that also the municipalities could benefit from having an increased focus on the crime-prevention purpose of preventive measures sentences, crime prevention measures and the rules on, among other things, leave.

By way of example, the municipal action plans received from 15 of the visited facilities either contained no targets or initiatives focused on crime prevention measures or only contained quite general targets for the measures. A first review of 15 examples of decisions on placement of a convicted person with intellectual and developmental disabilities in a social residential facility pursuant to a preventive measures sentence also indicated that municipalities do not always manage to make a decision in immediate continuation of the preventive measures sentence or of a change in the preventive measures sentence. Lastly, some of the social residential facilities stated that there could be differences in the municipalities' interpretation of the Leave Order.

The Ombudsman will discuss the information on the municipalities' execution of the tasks in this field which the Ombudsman received in connection with the monitoring visits with the Ministry of Social Affairs and Senior Citizens and with Local Government Denmark, including whether also the municipalities have a need for an increased focus on the crime prevention purpose of preventive measures sentences.

In addition, the Ombudsman will discuss the varied use of consultation councils with the Ministry of Social Affairs and Senior Citizens and with the Ministry of Justice.

Yours sincerely,

Niels Fenger

Parliamentary Ombudsman

Appendix 1 – Summary of the Ombudsman's case about the interpretation of the Leave Order

In continuation of the monitoring visits, the Ombudsman started an own-initiative case on the interpretation of the rules on leave from the facility where a person with a preventive measures sentence has been placed.

The rules are to be found in Executive Order No. 200 of 25 March 2004 on leave etc. for persons who have been placed at a hospital or an institution according to a criminal sentence or pursuant to a decree on dangerous behaviour, as amended by Executive Order No. 1184 of 6 December 20212 (the Leave Order).

The rules apply to convicted persons with a preventive measures sentence type 1-3.

The following appears from the Ombudsman's statement in the case:

- When the Leave Order refers to 'the county council', it must be understood to mean the municipal council whose duty it is to provide assistance to the citizen.

- The municipality cannot make a decision on urgent admission to a psychiatric ward.

- A social residential facility's principal can only make a decision on leave in those instances where the municipality can make a decision on leave, and where the municipal council – within the same municipal organisation – has delegated its authority to the social residential facility's principal.

- Social residential facilities do not have an independent authority to make decisions on leave for emergency hospitalisation.

- It is not a requirement that decisions on permission for leave must be made on the same day as the leave is held.

- The municipality can only give single permissions for escorted leave for more than 3 hours.

- The municipality can give permission for several separate leaves, each lasting for less than 3 hours.

- The authority which has given permission for the leave must also decide whether the leave can be carried out if the social residential facility on the day of the leave considers that it will be unsafe to go through with the

leave.

- A temporary telephone system will be established to enable social residential facilities to reach the prosecution service in those situations where there is a need for the prosecution service to consider revoking a leave permission issued by the prosecution service. The Ministry of Social Affairs and Senior Citizens will enter into a dialogue with Local Government Denmark on the possibility of establishing a similar telephone system in relation to revocation of those decisions on leave that the municipal council has made.

- The municipalities cannot demand that an application for permission on leave be submitted 30 days at the latest before the time of the desired leave.

- It can be left to the convicted person's relatives to supervise the convicted person during escorted leave of more than 3 hours' duration.

- Only the social residential facility's staff can supervise the convicted person during escorted leave of less than 3 hours' duration.

- The Leave Order will be amended, and it is expected that, in the coming parliamentary session, an initiative will be taken for a revision of the rules on leave.

In his statement, the Ombudsman pointed out a number of practical challenges which he had learned during his monitoring visits that the current scheme in the Leave Order can cause.

Appendix 2 – Outline of rules on conditions for convicted persons with intellectual and developmental disabilities

Criminal Code
(Consolidation Act No.1851 of 20 September 2021)

- Section 16 – rules on exemption from punishment due to an intellectual and developmental disability ('mental retardation')

- Sections 68 and 69 – rules on other measures than punishment found suitable to prevent further offences

- Sections 68 a and 69 a – rules on duration and extension of certain preventive measures sentences and indefinite preventive measures sentences

- Section 71 – rules on the appointment of a social security guardian

- Section 72 – rules on the public prosecutors' supervision of preventive measures sentences and on modification and termination of preventive measures sentences.

Act on Legal Protection and Administration in Social Matters
(Consolidation Act No.1647 of 4 August 2021)

- Section 9 – rules on the residential municipality, and on which municipality is obliged to provide assistance to a citizen (the acting residential municipality. In Danish, 'handlekommune'). Includes rules on the possibility of authorising the residential municipality to discharge the duties of the acting residential municipality.

- Section 16 a – rules on the acting residential municipality's duty to carry out supervision for crime-prevention purposes.

Act on Social Services
(Consolidation Act No. 1548 of 1 July 2021)

- Chapter 16 – rules on personal assistance, care and attendance

- Chapter 18 – rules on treatment, including social treatment for drug abuse

- Section 108 – rules on facilities suitable for long-term accommodation for persons who, due to substantial and permanent impairment of physical or mental function, need extensive assistance for general day-to-day functions or care, attendance or treatment where such needs cannot be

addressed in any other way. Such accommodation is referred to in this report as 'social residential facility'. Also rules on the municipalities' duty to receive persons who have been ordered by the court to be accommodated in facilities for persons with substantial impairment of mental function or to be subject to supervision.

- Chapter 24 and 24 a – rules on forcible measures and other restrictions of the right of self-determination. Also contain rules on registration and reporting of the forcible measures and other restrictions, and on informing relatives of forcible measures and restrictions and of channels of complaint and judicial review.

- Chapter 24 d – rules on enforcement of criminal sanctions etc. Contains, among other things, authority to restrict access to telephone and the internet and to lock the convicted person in his or her housing unit at night. Also contains rules on registration and reporting of restrictions and channels of complaint

- Section 140 – rules on the municipality's action plans. There is, among other things, a duty to draw up an action plan when a citizen has been the subject of a use of force

- Section 148 – rules on supervision of support and services to the individual citizens

- Chapter 30 – rules on complaint and judicial review

The Health Care Act
(Consolidation Act No. 903 of 26 August 2019)

- Chapter 40 – rules on treatment for alcohol abuse

- Chapter 41 – rules on sessions with doctors and medical drug abuse treatment

The Guardianship Act
(Consolidation Act No. 1122 of 28 May 2021)

- Chapter 2 – rules on guardianship for adults

- Chapter 3 – rules on guardianship and guardian cases regarding adults

The Executive Order on Leave
(Executive Order No. 200 of 25 March 2004, as amended by Executive Order No. 1184 of 6 December 2012)

- Rules on permission for temporary leave from the social residential facility, including who shall make the decision and what to take into account when making the decision

Executive Order on guardian representatives
(Executive Order No. 947 of 24 September 2009, as amended by Executive Order No. 1512 of 17 December 2019)

- Rules on the approval and appointment of guardian representatives and duties and powers of guardian representatives

Executive Order on forcible measures and other restrictions in the right of self-determination towards adults, and on special safety measures for adults and on duty to receive persons in accommodations pursuant to the Social Services Act
(Executive Order No. 1239 of 22 November 2019)

- Rules on forcible measures and other restrictions

- Rules on registration and reporting

- Rules on secure units (units with locked outer doors and windows)

- Rules on the municipalities' duty to make decisions on convicted persons' stay in social residential facilities in accordance with a preventive measures sentence (duty to receive. In Danish, 'modtagepligt')

Thematic report 2020: Institutions for children and young people with disabilities

Contents

29 June 2021

Doc.No.
21/01069-2/CLA/skh

1. Introduction

1.1. Institutions for children and young people with disabilities was the theme of the monitoring visits that the Ombudsman carried out in the children's sector in 2020 in cooperation with the Danish Institute for Human Rights (IMR) and DIGNITY – the Danish Institute Against Torture.

The institutions that the Ombudsman visited in connection with the theme had different target groups. The target groups varied from children and young people with mild or moderate physical, mental or cognitive disabilities to children and young people with substantial physical, mental or cognitive disabilities.

For instance, there were children and young people with cerebral palsy (spastic paralysis), scoliosis, heart defects, epilepsy, vision and hearing impairment, intellectual disabilities and autism spectrum disorders.

1.2. The Ombudsman carried out a total of eight monitoring visits in order to examine the theme of the year. The Ombudsman visited six open residential institutions and two private accommodation facilities. All visits were fully or partly announced in advance.

Six visits were carried out physically while two visits were carried out virtually due to the COVID-19 situation.

The Ombudsman visited four in-house schools in connection with the monitoring visits – three in-house schools at residential institutions and one in-house school at a day-care facility.

1.3. During the monitoring visits, the focus was especially on:

- Use of physical force
- Prevention of violence and sexual assaults and the procedure in connection with suspicion of assault
- Education.

During the monitoring visits, focus was also on for instance healthcare conditions, including the medicines management by the visited facilities and institutions.

2. What have the thematic visits shown?

2.1. Main conclusions

Use of physical force

- The visited facilities and institutions were generally reflective in relation to the dilemmas that could arise in the field of tension between force and care, and overall, the monitoring visits left the impression that the facilities and institutions were good at handling these dilemmas pedagogically in a constructive and development-oriented manner.

- To a great extent, the deadline for recording and reporting use of force was not observed, and the report forms in many cases did not contain an adequate description of the course of events or grounds for the necessity of the measure.

Prevention of violence and sexual assaults and the procedure in connection with suspicion of assault

- Not all facilities and institutions had written guidelines on both prevention of violence and sexual assaults and on the procedure in connection with suspicion of assault. A few facilities and institutions also needed to ensure that the staff, including through written guidelines, had sufficient knowledge about signs of sexual assaults.

Education in in-house schools

- None of the in-house schools that were meant to have an agreement with the municipality of location regarding schooling had an agreement that fully observed the legislative requirements.

- Several of the in-house schools were challenged with regard to observing the rules on teaching the full range of subjects and on the number of teaching hours, and with the rules on exemption from lessons in subjects, mandatory tests and examinations of the Danish Folkeskole (the Danish municipal primary and lower secondary school).

2.2. General recommendations

Based on the monitoring visits, the Ombudsman generally recommends that accommodation facilities and residential institutions:

- ensure the observation of deadlines for recording use of force and deadlines for reporting to and informing the relevant authorities and custodial parents of use of force.

- ensure that report forms on use of force contain an adequate description of the course of events, including a description of how specifically the child or young person was led or restrained as well as the grounds for the necessity of the measure.

- ensure that the staff are sufficiently familiar with the Danish Act on Adult Responsibility towards Children in Foster Care and with what restraining holds to use in connection with use of force so that the force is used as gently as possible, and that the facilities and institutions have written guidelines on use of physical force.

- ensure that children, young people and custodial parents are informed on arrival about their rights in relation to use of force and other restrictions of the right of self-determination, including the right to complain. In this context, the Ombudsman recommends that accommodation facilities and residential institutions consider drawing up written material on rights and channels of complaint which can be given to the children, young people and custodial parents on arrival.

- ensure that the staff at institutions for children and young people with disabilities are aware of what physical and mental signs that– taking into account the target group and the specific group of children – they must look out for in relation to suspicion of sexual assaults, and that the institutions have written guidelines on prevention of violence and sexual assaults and on the procedure in connection with suspicion of assault.

- ensure that the instructions on medicines management are prepared in accordance with the Danish Health Authority's guidelines on the drawing-up of instructions.

Based on the monitoring visits, the Ombudsman also generally recommends that facilities and institutions with in-house schools:

- in cooperation with the municipality of location ensure that the agreement on schooling in the in-house school is in accordance with the applicable rules.

- ensure that all pupils are taught the full range of subjects and number of teaching hours, and that exceptions from this are only made if a pupil – based on a concrete and individual assessment – is exempted from lessons in one or more subjects or has the teaching time reduced in

accordance with the applicable rules, and ensure that exemptions from lessons in subjects are decided in accordance with the rules, and that there is documentation for this.

- ensure that exemptions from mandatory tests and Folkeskole examinations are decided in accordance with the rules, and that there is documentation for this.

The Ombudsman will discuss the follow-up on these general recommendations with, respectively, the Ministry of Social Affairs and Senior Citizens, the Ministry of Children and Education, and the Ministry of Health.

The Ombudsman will also follow up on the general recommendations during future monitoring visits.

2.3. Background for the choice of theme and focus points

2.3.1. Children and young people with physical, mental or cognitive disabilities may often be vulnerable and have few resources. They may find it difficult to understand the world around them and to interact and communicate with other children and adults. The Ombudsman is only rarely contacted by children and young people with disabilities who are placed outside the home, and when it does happen, their functional capacity is typically only affected to a lesser extent by their disability.

With this theme, the Ombudsman wanted a more general view of the conditions for children and young people who are placed in care or attending institutions for children and young people with disabilities.

2.3.2. During the visits, the Ombudsman focused on the extent to which physical force is used in institutions for children and young people with disabilities. Among other things, this is due to the fact that it can be a distressing experience to be the subject of physical force or to witness others being the subject of physical force. The Ombudsman also endeavoured to examine whether the institutions find that dilemmas arise between force and care, for instance in connection with fall prevention, daily hygiene (showers/baths, tooth brushing, etc.).

The Ombudsman also wanted an insight into how institutions for children and young people with disabilities prevent violence and sexual assaults, and what procedure the institutions follow in the event of suspicion of assault. This is because investigations show that children and young people with disabilities are at greater risk of being the subject of violence or sexual assaults than children and young people without disabilities. In addition, some children and

young people with disabilities cannot or find it difficult to express that they have been subject to an assault, for instance because they have no language or due to their cognitive level.

Moreover, the Ombudsman wanted to follow up on a general recommendation in the thematic report for 2015 to institutions where children and young people go or live due to their substantial and permanent functional impairment that the institutions draw up written guidelines on how they prevent sexual assaults and on which procedure they follow if there is suspicion of assault.

During the monitoring visits, the Ombudsman also wanted to examine whether children and young people with disabilities who are placed in care and attend in-house schools are getting the education they are entitled to according to legislation.

In addition, the Ombudsman wanted to examine the children and young people's access to health services and the medicines management by the visited facilities and institutions. This is because it is important that the staff manage medicines in accordance with the applicable rules in order to prevent medication errors, among other things.

2.4. How did the Ombudsman proceed?

2.4.1. Prior to most of the monitoring visits, the Ombudsman asked the facilities and institutions for a range of information with a view to shedding light on the conditions that the Ombudsman would focus on during the visits. This included the following information:

- A summary of the number of times when force has been used within the most recent three years with a copy of the five most recent reports on use of physical force towards children and young people at the facility or institution.

- An account of the reasons for any development in the use of physical force, how the facility or institution prevents the use of physical force, and how children and young people who have been involved in an episode where physical force was used get the opportunity to comment on the episode.

- Any guidelines on use of physical force and information on how children, young people and custodial parents are informed of their rights in relation to the use of force and other restrictions of the right to self-determination, including the right to complain.

- An account of the reason for any development in the number of cases of violence and sexual assaults, respectively.

- Any guidelines on preventing, discovering and handling suspicions of violence and sexual assaults.

- The facility or institution's instructions for medicines management and an account of how the children and young people's access to health services is organised.

If the facility or institution had an in-house school, the Ombudsman also asked for, for instance, a copy of the three most recent exemptions from lessons in one or more subjects, the three most recent exemptions from mandatory tests and the three most recent exemptions from Folkeskole examinations. Furthermore, the Ombudsman asked for a copy of the agreement with the municipality of location regarding the schooling in the in-house school where such an agreement had been made.

2.4.2. In the week leading up to the monitoring visits, the Ombudsman informed the children and young people of the visit. This was done by sending the children and young people a card with a QR code. By using the QR code, the children and young people had access to a film with information about the Ombudsman's Children's Division, the upcoming monitoring visit and the subjects that the visiting teams would like to talk with the children and young people about. The film can be seen in Danish here: http://boernekontoret.ombudsmanden.dk/besoeg/. The aim was to reach as many children and young people as possible, because their experience of how it is to live in the facility or institution is a significant and important source of information.

During the monitoring visits, the visiting teams interviewed 24 children and young people aged 10-17. The reason they did not speak with more was that many of the children and young people living at the facilities and institutions had very limited language or none at all due to their disabilities.

To get an insight into the facilities and institutions as well as the children and young people's conditions at the facilities and institutions, the visiting teams also spoke with a number of the children and young people's relatives, primarily parents. The visiting teams spoke with 53 relatives. In addition, the visiting teams spoke with staff at the facilities and institutions, including in-house school teachers and those responsible for medicines who also contributed with information about the visited facilities and institutions and the children and young people's conditions. Finally, the visiting teams obtained information about the visited facilities and institutions in connection with the discussions with management during the monitoring visits.

2.4.3. The monitoring visits were carried out as part of the Ombudsman's general monitoring activities pursuant to the Parliamentary Ombudsman Act, and as part of the Ombudsman's task of preventing that persons 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).

In addition, the Ombudsman has a special responsibility for protecting children's rights pursuant to the UN Convention on the Rights of the Child, among other things.

The Ombudsman's work on preventing degrading treatment etc., pursuant to the Protocol is carried out in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

The Danish Institute for Human Rights and DIGNITY contribute to the cooperation with human rights and medical expertise. For instance, this means that staff with expertise in these areas participate on behalf of the two institutes in the planning and execution of and follow-up on monitoring visits.

In addition, a special advisor on children's issues from the Ombudsman's office participates in monitoring visits to the children's sector.

2.4.4. At the Ombudsman's website, there is a summary of all the monitoring visits carried out in 2020, including the recommendations given to the individual facilities and institutions: Monitoring visits to institutions etc. for children in 2020 (ombudsmanden.dk).

3. Use of physical force

3.1. The rules

The best interest of the child shall be a primary consideration in all actions concerning children, says the UN Convention on the Rights of the Child.

According to the Act on Adult Responsibility, staff at accommodation facilities and residential institutions can use physical force towards a child or a young person when certain specified conditions are met.

However, physical force must only be used as an exception. And use of physical force must never take the place of care and social-pedagogical measures. In addition, the use of force must always be in reasonable proportion to the aim and must be exercised as gently and as briefly as

conditions allow, and with the highest possible regard for the personal integrity of the child or young person.

USE OF PHYSICAL FORCE AT ACCOMMODATION FACILITIES AND OPEN RESIDENTIAL INSTITUTIONS

Who and what
Staff can *restrain* or *lead* a child or a young person to another room.

When
Physical force can be used when the child or the young person exhibits a behaviour, including persistent harassment, which *endangers the child or the young person or others at the location*.

Documentation and hearing
The facility or institution must *record and report* use of physical force.

The child or young person must be *informed of the report* and be given the *opportunity to comment*.

Information
The child or young person and custodial parents must be *informed of their rights in relation to the use of force and other restrictions of the right to self-determination*, including channels of complaint, when they arrive at the placement.

Restrain means that a child or a young person can be restrained physically, for instance by holding the child or young person in the form of placing your arms around the child or young person while you are standing still. Restraint must never include violence, including violent armlocks, punches or kicks. Nor is the one carrying out the restraint allowed to lie down on top of the child or young person and restrain the individual with his or her body weight.

Lead to another room means that a child or young person can be taken to another room in the placement facility or institution such as the individual's own room. Restraining or leading can for instance be done by having a firm hold of the child or young person's hand and leading him or her to another room. You can also lead the child or young person while you have your arms around them. The crucial factor is that the child or young person is not harmed.

The rules on use of physical force in the Act on Adult Responsibility apply to children and young people placed at an accommodation facility or a

residential institution. However, the rules do not apply to children and young people who are in respite care at an accommodation facility or a residential institution.

The Act on Adult Responsibility's rules on the use of physical force also apply to the in-house schools connected with accommodation facilities and residential institutions. However, they only apply to pupils who have been placed at the accommodation facility or residential institution or another accommodation facility or residential institution. With regard to other pupils who are in an in-house school, the rules of the Executive Order on Measures for the Promotion of Good Order in the Folkeskole apply.

3.2. Extent of the use of physical force

There was great variation between the sizes of the visited facilities and institutions and between the extent and nature of the children and young people's disabilities. For this reason, among others, the annual number of incidents of use of physical force at the facilities and institutions varied a great deal. As such, the number of incidents of use of force in 2019 varied from 1 to 137 incidents.

Some of the visited facilities and institutions stated that a significant amount of the use of force was centred on a single child/young person or a few children and young people. One place stated that, out of the 121 incidents of use of force that took place there in 2019, 107 concerned three children, of which 98 concerned one child. In several cases, it was stated that the child or young person who had been involved in a relatively large number of incidents was no longer staying at the facility or institution or would be moved to a different placement facility or institution.

All the visited facilities and institutions explained to a relevant extent how they worked on preventing the use of force. For example, they used Low Arousal, KRAP (cognitive, resource-oriented and acknowledging pedagogics), ART (Anger Replacement Training), ICDP (International Child Development Program), diversion, staff changes, information sharing and risk assessments.

The Ombudsman recommended four places to continue their work of preventing and reducing the number of incidents of use of force.

3.3. Examples of reports on the use of physical force

Accommodation facilities and residential institutions must record use of physical force in a specific form. The form can be seen in Appendix 1 a of the Executive Order on Adult Responsibility for Children and Young People in Out-of-Home Care.

In connection with the monitoring visits, the Ombudsman asked to receive the five most recent report forms on use of physical force.

The Ombudsman received a total of 46 reports on use of physical force. The review of the reports formed a basis for discussions between the visiting teams and the visited facilities and institutions during the monitoring visits.

The visited facilities and institutions generally used the correct form to record use of physical force, but the Ombudsman recommended one place to use the form in the Executive Order.

3.3.1. Observance of deadlines for recording and reporting use of physical force

If force has been used towards a child or a young person, the manager of the placement facility or institution (or the deputy manager) must, pursuant to the rules on adult responsibility, record the incident in the report form in Appendix 1 a mentioned above within 24 hours. The short deadline is primarily out of regard for the legal rights of the child or young person, but also out of regard for the staff involved in the incident.

Then the manager (or deputy manager) of the placement facility or institution must without undue delay send a copy of the report form to the placing municipality and inform the custodial parents. By the requirement of 'without undue delay' is meant as quickly as possible within 24 hours once the recording has been completed. At the end of the month, a copy of the report form must be sent to the local social supervisory authority, and a possible municipal or regional operator must be informed.

If the use of force has taken place in an in-house school, the use of force must in addition be reported to the municipality of location (the municipality in which the school is placed).

The review of the 46 report forms showed that none of the visited facilities or institutions fully observed the deadlines for recording and reporting use of physical force.

The deadline for *recording the use of force* was thus only observed in 12 out of the 46 forms. In a number of instances, the deadline for *reporting the use of force* was not observed.

Only in four out of the 46 forms (corresponding to nine per cent), all deadlines for recording, reporting and informing of a use of force was observed.

On that basis, the Ombudsman recommended to six places that they observe the deadlines for recording and reporting use of force, while two places were

recommended to ensure that the report forms are completed correctly as far as the time of recording and reporting are concerned.

On that basis, the Ombudsman generally recommends that accommodation facilities and residential institutions ensure that deadlines for recording use of force and the deadlines for reporting to and informing the relevant authorities and custodial parents of use of force are observed.

3.3.2. Documentation for use of force

Use of physical force that takes place at an accommodation facility or residential institution must be recorded in the report form mentioned in sub-heading 3.3 above. The report form must contain a description of what happened in connection with the use of force as well as grounds for the necessity of the measure.

An adequate description of the course of events in connection with a use of force and a precise account of how the child or young person was led or restrained are a prerequisite for being able to assess whether the use of force was in accordance with the rules of the Act on Adult Responsibility.

Some of the report forms that the Ombudsman received did not contain an adequate description of the course of events or of how the use of force was carried out. For example, in several instances, it was only stated that a child or young person was restrained gently or laid down but not how this happened or where and how the staff member restrained the child or young person. Furthermore, some forms did not contain information about the basis on which the child or young person was assessed to endanger themselves or others.

Therefore, the Ombudsman gave recommendations to three places with the purpose of ensuring that the report forms would in future contain an adequate description of the course of events in connection with use of force and the grounds for the measure.

The Ombudsman generally recommends that accommodation facilities and residential institutions ensure that report forms on use of force contain an adequate description of the course of events, including a description of how specifically the child or young person was led or restrained as well as grounds for the necessity of the measure.

3.3.3. Inclusion of the child or young person

Children and young people who have been involved in a physical force incident must be informed of the recording of the episode and be given the opportunity to comment on the episode. This follows from the legislation on adult responsibility.

The review of the report forms that the Ombudsman received on use of physical force showed that the visited facilities and institutions did not in all instances make the child or young person aware of the recording or give the child or young person an opportunity to comment on the episode.

However, in most of the instances, this was due to the extent and nature of the child or young person's disability, for instance a very low cognitive level or limited language. It was the visiting teams' general impression that the facilities and institutions spoke with the children and young people about the use of force to the extent possible, taking into account their disabilities.

The Ombudsman gave no recommendations on the inclusion of the children and young people.

3.4. Knowledge of the Act on Adult Responsibility and use of force

Children and young people living at accommodation facilities and residential institutions or attending in-house schools in accommodation facilities and residential institutions must be treated with dignity, consideration and in accordance with their rights. In order to ensure this, it is, among other things, crucial that staff are familiar with the rules applying to use of physical force towards the children and young people.

Use of physical force must be applied as gently and as briefly as circumstances allow and with the greatest possible consideration for the personal integrity of the child or young person. Among other things, this presupposes that staff know what restraining holds to use in connection with use of force.

In that connection, written guidelines on use of physical force can provide support and help in the daily work.

The visiting teams got the impression during the majority of the monitoring visits that the facilities and institutions focused on ensuring that the staff were familiar with the rules of the Act on Adult Responsibility, for instance through training courses. In addition, many of the facilities and institutions had written guidelines on use of physical force.

The Ombudsman recommended two places to continue the work with ensuring that the staff had sufficient knowledge about the rules on use of force, and recommended two places to consider a training course for the staff on using gentle holds in connection with the use of force.

Moreover, the Ombudsman recommended five places to consider preparing or developing existing guidelines on use of physical force.

In the light of this, the Ombudsman generally recommends that accommodation facilities and residential institutions ensure that staff have sufficient knowledge of the Act on Adult Responsibility and of what restraining holds to use in connection with use of force so that the use of force is carried out most gently, and that the places have written guidelines on use of physical force.

3.5. Dilemmas between force and care

Children and young people with disabilities may find it difficult or be unable to understand or foresee the consequences of their actions. For example, they may be unable to foresee the consequence of not taking their medication, not brushing their teeth or refusing to participate in a medical examination. Due to this, dilemmas may arise between force and care.

Most of the facilities and institutions stated that they experienced dilemmas between force and care. For instance, there were dilemmas in connection with tooth brushing and giving medicine, and dilemmas could arise between force and care in connection with the children and young people going to the doctor, dentist or hairdresser.

The visits left the impression that the facilities and institutions were generally reflective in relation to the dilemmas that could arise in the field of tension between force and care, and they were good at handling these dilemmas pedagogically in a constructive and development-oriented manner.

The Ombudsman gave no recommendations concerning the places' handling of dilemmas between force and care. However, the Ombudsman took initiative to open a case about an institution's use of beds with high sides (cots) and the institution's locking system with a view to clarifying the legal grounds for the use thereof. In a statement in the case, the Ministry of Social Affairs and Senior Citizens assessed that – depending on for instance the age of the children and young people and whether or not they have functional disabilities – in accordance with institution status and on certain conditions, there was access to using cots as well as access to using locking systems with, for instance, several doorknobs, door-openers or similar on some outer doors at open residential institutions. When the institution stated that its use of cots and its locking system were in accordance with what was set out by the Ministry, the Ombudsman took no further action in the matter.

3.6. Information on rights

When a child or a young person is placed at an accommodation facility or a residential institution, the manager must inform the child or young person and the custodial parents of their rights in relation to use of force and other restrictions of the right to self-determination, including channels of complaint

to the National Social Appeals Board and the municipal council. This follows from the legislation on adult responsibility.

If information on rights and channels of complaint is given in writing, the language should be easy to understand.

The visits showed that several facilities and institutions had not on arrival informed children, young people and custodial parents of their rights in relation to use of force etc.

The Ombudsman recommended to four places that they ensure that the custodial parents – and to the extent possible also children and young people with disabilities – are informed on arrival of their rights in relation to use of force and other restrictions of the right to self-determination, including channels of complaint. In addition, The Ombudsman recommended to one place that it complete the preparation of written material with information to children, young people and custodial parents of their rights in relation to use of force etc., including channels of complaint.

The Ombudsman generally recommends that accommodation facilities and residential institutions ensure that children, young people and custodial parents are informed of their rights in relation to use of force and other restrictions of the right to self-determination, including channels of complaint, when moving in. In this connection, the Ombudsman recommends that accommodation facilities and residential institutions consider drawing up written material on rights and channels of complaint which can be given to the children, young people and custodial parents on arrival.

4. Prevention of violence and sexual assaults and the procedure in connection with suspicion of assault

4.1. Rules etc.

Children must be protected from all forms of violence, sexual exploitation and sexual abuse. This follows from the UN Convention on the Rights of the Child.

In 2015, the Ombudsman visited a number of institutions for children and young people with substantial and permanent functional impairment. Based on the monitoring visits, the Ombudsman generally recommended that such institutions draw up written guidelines on how sexual assaults can be prevented and on which procedure the institution follows if there is suspicion of assault.

The Ombudsman discussed the follow-up of his general recommendation with the Ministry of Social Affairs and the Interior (now the Ministry of Social Affairs and Senior Citizens), the National Board of Social Services and the social supervision authorities.

Subsequently, the National Board of Social Services has issued a handbook about preventing, discovering and handling violent and sexual assaults against children with cognitive or physical disabilities. The handbook is available in Danish at the National Board of Social Services' website (Vold og seksuelle overgreb mod børn med handicap - Socialstyrelsen - Viden til gavn), where there is also a template with suggestions for the contents of a policy for preventing and discovering violence and sexual assaults against children and young people with disabilities.

4.2. Recording violence and sexual assaults

4.2.1. The places that the Ombudsman visited in connection with the monitoring visits in 2020 did not have consistent practices for recording violence, threats, harassment, etc. For example, there was variation in what types of incidents the places recorded, how the incidents were classified, and how severe an incident had to be in order to be recorded. For example, one place stated that an incident was recorded as violence merely if there had been physical contact, whereas in another place, it took more (several punches) before the incident was recorded. A third place registered incidents where a child was bothered by another child's noises on an overview of violence and harassment.

In relation to the number of recorded episodes, one place had recorded no incidents of violence in the period 2017-2019, and other places had recorded few incidents of violence. A few places had recorded relatively many incidents of violence etc. In the latter case, by far most of the recorded incidents of violence etc. were exercised by one child (or few children) and were directed at staff at the facility or institution.

4.2.2. The places visited by the Ombudsman also did not have consistent practices for recording sexual assaults etc.

Most of the places had not in the period 2017-2019 recorded any sexual assaults, whereas a few places stated that such incidents had been recorded during the period. The incidents were few, and only children or young people had been involved.

4.3. Prevention of violence and sexual assaults

4.3.1. The places prevented violence for instance by having the staff:

- talk to the children and young people about how to express frustration and anger in the most appropriate way.

- receive training and supervision in relation to conflict management.

- use conflict de-escalating methods and approaches, including KRAP, Low Arousal, diversion, clearly defined settings and structure, etc.

- use risk profiles and risk assessments systematically.

4.3.2. The places prevented sexual assaults by for instance:

- having a sexual harassment policy with guidelines for various situations, including showering or bathing.

- ensuring that staff had knowledge about children and young people's sexuality, sexual development etc. and knowledge about signs that a child or young person had been subject to a sexual assault.

- having group meetings or individual conversations with the children and young people about love, sexuality, sexual development and boundaries as well as behaviour online or on other digital media etc.

- employing or affiliating with staff who were trained sex counsellors or trained in preventing, discovering and handling suspicion of sexual assaults against children.

- having increased attention on children who, because of their diagnoses, found it difficult to set boundaries or understand others' boundaries.

- having a night watch who was awake.

Some places stated that they had challenges in relation to the children and young people's use of mobile phones with internet connection, including use of social media, because not all children and young people understand the consequences of their actions online. It was stated that this could manifest itself in the children and young people, for instance, sending nude photos to strangers who contact them via social media or by sharing such photos. Some places found it difficult to protect the children and young people within the existing legal framework.

4.4. Guidelines on prevention of violence and sexual assaults and on the procedure in connection with suspicion of assault

Some of the visited facilities and institutions had written guidelines involving both prevention of violence and sexual assaults and the procedure to be followed in the event of suspicion of assault.

Other places had no or only partly written guidelines in this respect.

The Ombudsman recommended to six places that they ensure that the places had written guidelines on both the prevention of violence and sexual assaults and on the procedure in connection with suspicion of assault.

In individual places, the Ombudsman also recommended that they ensure that the staff had knowledge about signs of sexual assaults, for instance by updating the place's sexual harassment policy, and that they ensure that there is attention on the children and young people learning to manage their sexuality to a relevant extent.

The Ombudsman generally recommends that accommodation facilities and residential institutions for children and young people with disabilities ensure that the staff are aware of what physical and mental signs that – taking into account the target group and the specific group of children – they must look out for in relation to suspicion of sexual assaults.

The Ombudsman also generally recommends that accommodation facilities and residential institutions for children and young people with disabilities have written guidelines on prevention of violence and sexual assaults and on the procedure in connection with suspicion of assault.

5. Education in in-house schools

5.1. The rules

A child is entitled to education. This follows from the UN Convention on the Rights of the Child.

The rules on primary and lower secondary school education appear from the Danish Folkeskole Act with related executive orders and guidelines. Among other things, an executive order has been issued on special educational teaching and other kinds of specialist pedagogical assistance under the Act in day-care facilities and at other placement facilities and institutions.

Children and young people attending an in-house school are entitled to the same education as children and young people attending a Folkeskole. This means that they must be taught the full range of subjects of the Folkeskole

and the number of hours laid down in the Folkeskole Act, unless they can be exempted from lessons in one or more subjects or have the class hours reduced in accordance with applicable rules.

5.2. The visited in-house schools

The Ombudsman visited four in-house schools in connection with the monitoring visits in 2020. They consisted of one in-house school at a day-care facility and three in-house schools at one municipal and two regional residential facilities, respectively.

In the three in-house schools at residential institutions, there were both children and young people living at the facility or institution (live-in pupils) and children and young people who did not live at the facility or institution (external pupils). The external pupils either lived at home with their parents or were placed at another facility or institution.

There was great variation between the pupils at the in-house schools. While for some pupils, it took a lot of effort to participate in schooling, the visiting team also met a pupil whom a teacher at the in-house school assessed would be able to sit the Folkeskole's final examinations and attend an upper secondary school targeted at young people with the same disabilities as the pupil.

5.3. Agreements

5.3.1. Accommodation facilities, regional residential institutions and day-care facilities with in-house schools must enter into an agreement with the municipality of location regarding schooling. The Executive Order on Special Educational Teaching, etc. (mentioned above under heading 5.1) lists a number of elements which the agreement must observe as a minimum, including the pedagogical-psychological services and the recording and reporting to the municipal council of use of force towards pupils.

At the time of three of the monitoring visits at facilities and institutions with in-house schools, Executive Order No. 702 of 23 June 2014 on Special Educational Teaching, etc. applied. Before the visit to the fourth place with an in-house school, the Executive Order was amended, meaning that it included additional requirements for the contents of the agreement. On that basis, the fourth place was recommended to update the agreement in accordance with the new Executive Order.

5.3.2. During the monitoring visits, the Ombudsman examined whether – to the extent required – the places had entered into an agreement with the municipality of location, and whether the contents of the agreement met the requirements of the Executive Order.

Three of the visited facilities and institutions with in-house schools were required to enter into an agreement with the municipality of location regarding schooling, and all three places had entered into such an agreement. However, none of the three agreements fully met the Executive Order's requirements to the contents of an agreement.

One of the agreements did not contain a correct and adequate description of the pedagogical-psychological services. The agreement also did not contain a correct description of the rules on recording and reporting use of force towards pupils in the in-house school. Furthermore, two agreements contained references to previous – and not applicable – rules on the subject.

On that basis, the Ombudsman recommended three places with in-house schools to – in cooperation with the municipality of location – update their agreement regarding schooling.

The Ombudsman generally recommends that facilities and institutions with in-house schools – in cooperation with the municipality of location – ensure that the agreement regarding schooling in the in-house school is in accordance with the applicable rules.

5.4. Teaching the full range of subjects and hours

5.4.1. As mentioned above, children and young people attending an in-house school are generally entitled to schooling in the full range of subjects of the Folkeskole and for the number of hours stipulated in the Folkeskole Act.

Range of subjects and hours, including the minimum hours in, respectively, Danish and history and the overall annual minimum hours, vary from grade to grade. There is also a minimum number of hours required in maths that does not vary from grade to grade.

5.4.2. The visits showed that two of the four in-house schools did not observe the rules on teaching the full range of subjects and hours.

On that basis, the Ombudsman recommended to observe the rules on teaching the full range of subjects and hours, including the rules on reduction of class hours.

The Ombudsman generally recommends that facilities and institutions with in-house schools ensure that all pupils are taught the full range of subjects and number of hours, and that exceptions therefrom are only made if a pupil – based on a concrete and individual assessment – is exempted from

lessons in one or more subjects or has the class hours reduced subject to the applicable rules.

5.5. Exemption from lessons in subjects

5.5.1. It is possible to exempt pupils from lessons in one or more subjects, though not in Danish and maths. This follows from the executive orders on special educational teaching issued pursuant to the Folkeskole Act.

It is only possible to exempt a pupil from lessons in a subject if the pupil has extraordinary difficulties in mastering the subject, so that it is not deemed meaningful to give the pupil special educational teaching in the subject in question.

Exemption from lessons in a subject must be decided on the basis of a concrete and individual assessment of the pupil's difficulties with the subject. It is for instance not possible to exempt a pupil – or a group of pupils – from lessons in a subject on the grounds that the in-house school does not have a teacher who can teach the subject, that the in-house school does not have a classroom specially fitted for the subject, or that there are only one or a few pupils to be taught the subject in question.

A decision to exempt a pupil from lessons in a subject is made by the head of the school on the basis of a pedagogical-psychological assessment. In addition, the parents must give their consent to the exemption.

If a pupil is exempted from lessons in one or more subjects, the pupil must have other lessons instead of the subject(s) in question. It is therefore not possible to reduce the teaching hours of a pupil by exempting the pupil from lessons in one or more subjects.

5.5.2. The visits showed that, at three of the four in-house schools, there were problems with observing the rules on exemption from lessons in subjects.

One place stated that actual decisions were not made on exemption from lessons in subjects, but the issue of exemption was discussed at half-yearly meetings in which the parents participated. There was no documentation for the basis of the pupils' exemptions for lessons in subjects, even though most of the pupils at the in-house school were exempted from lessons in a number of subjects.

At another place, it appeared from the pupils' teaching plans in which subjects they were exempted from lessons, but in most cases, the teaching plans did not contain information documenting that the conditions for

exempting a pupil from lessons in the subject in question were met. At a third place, the exemptions from lessons in subjects appeared to be general and standardised, and thus not as concrete and individual assessments of the individual pupil's difficulties in the subjects in which they were exempted from lessons.

Furthermore, several places lacked documentation that the decisions on exemption from lessons in subjects were made on the basis of a pedagogical-psychological assessment.

It is important that pupils are only exempted from lessons in one or more subjects if the basic conditions are met. It is therefore also important that the in-house schools can document the grounds for the exemption, that the parents have given their consent to the exemption and that the decision has been made on the basis of a pedagogical-psychological assessment. This is because such documentation is decisive when verifying if the conditions for exempting a pupil from lessons in one or more subjects are met.

The Ombudsman recommended to three places that they ensure that the rules on exemption from lessons in subjects are observed.

The Ombudsman generally recommends that facilities and institutions with in-house schools ensure that decisions on exemption from lessons in school subjects are made in accordance with the rules, and that there is documentation for this.

5.6. Exemption from tests and examinations

5.6.1. Pupils in in-house schools must complete mandatory tests and sit the Folkeskole examinations in the same way as pupils taught in the Folkeskole, unless the pupils are exempted according to the applicable special rules. This follows from executive orders issued pursuant to the Folkeskole Act.

In connection with a decision on exemption from a mandatory test, the head of the school must, after consultation with the pupil's parents – and as far as possible with the pupil – determine which other methods for assessment of the pupil to use instead of the mandatory test.

Similarly, a decision on exemption from an examination test must be followed by a decision on how the pupil's benefit from the schooling can be assessed in another way.

5.6.2. The visits showed that, at three of the four in-house schools, there were problems with observing the rules on exemption from mandatory tests and Folkeskole examinations.

Although not all pupils at the in-house schools participated in mandatory tests and Folkeskole examinations, none of the three in-house schools had written documentation for exemptions from participation in mandatory tests and Folkeskole examinations, nor documentation that the procedure for exemptions had been followed.

For example, one place stated that the pupils at the in-house school did not participate in mandatory tests or Folkeskole examinations, but that exemptions were not made for each individual pupil.

On that basis, the Ombudsman recommended three places to ensure observance of the rules on exemption from participation in mandatory tests and Folkeskole examinations.

The Ombudsman generally recommends that facilities and institutions with in-house schools ensure that decisions on exemption from mandatory tests and Folkeskole examinations be made in accordance with the rules, and that there is documentation for this.

6. Health

6.1. General

A child has a right to the enjoyment of the highest attainable standard of health, access to facilities for the treatment of illnesses and rehabilitation of health. This follows from the UN Convention on the Rights of the Child.

A number of children and young people at the facilities and institutions visited by the Ombudsman had various health-related challenges of both a physical and mental nature, and several children and young people received medication.

During the visits, the facilities and institutions accounted for the children and young people's access to health services, including doctors, dentists and specialist doctors. The visits generally left the impression that the places to a relevant extent had focus on the children and young people's health-related conditions and their access to health services, and that the places followed up on any health-related challenges in an appropriate way.

The Ombudsman gave no recommendations on the children and young people's access to health services.

6.2. Medicines management and instructions on medicines management

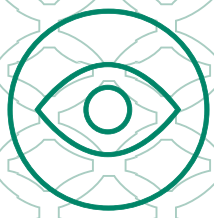
Correct medicines management is crucial to patient safety, and the Danish Health Authority has issued guidelines on drawing up instructions as well as guidelines on prescription and management of medicines. In addition, the Danish Patient Safety Authority has issued a folder on correct medicines management as a tool for care facilities, home care, community nursing, accommodation facilities, etc. ('*Korrekt håndtering af medicin – Et værktøj for plejecentre, hjemmepleje, hjemmesygepleje, bosteder m.v.'; in Danish only*).

None of the facilities and institutions were given recommendations concerning their medicines management, but some places were given recommendations concerning their instructions on medicines management, for instance to either draw up or update their instructions on medicines management in order to ensure that they were in accordance with the Danish Health Authority's guidelines on issuing instructions.

The Ombudsman generally recommends that accommodation facilities and residential institutions ensure that instructions on medicines management are drawn up in accordance with the Danish Health Authority's guidelines on drawing up instructions.

Yours sincerely,

Niels Fenger



Part Four

Appendix

General information about the Danish Parliamentary Ombudsman and about monitoring visits under the OPCAT mandate

1. General information about the Danish Parliamentary Ombudsman

The task of the Parliamentary Ombudsman

The Danish Parliamentary Ombudsman was established in 1955 following a constitutional amendment in 1953. The general background to introducing a Parliamentary Ombudsman was a wish to improve the protection of citizens' legal rights vis-à-vis public authorities.

The primary task of the Parliamentary Ombudsman is to help ensure that administrative authorities act in accordance with the law and good administrative practice, thus protecting citizens' rights vis-à-vis the authorities. An additional function of the Ombudsman is to support and promote good administrative culture within the public administration.

The Parliamentary Ombudsman is not the National Human Rights Institution of Denmark. The Danish Institute for Human Rights carries out this mandate.

Relationship to Parliament and jurisdiction

The Parliamentary Ombudsman is governed by the Ombudsman Act.

The Parliamentary Ombudsman is organisationally linked to the Danish Parliament. After each general election and whenever a vacancy occurs, Parliament elects an Ombudsman. Further, Parliament may dismiss the Ombudsman if the person holding the office no longer enjoys its confidence. However, the Ombudsman Act stipulates that the Ombudsman is independent of Parliament in the discharge of his functions.

Under the Ombudsman Act, the jurisdiction of the Parliamentary Ombudsman extends to all parts of the public administration: the state, the regions, the municipalities and other public bodies.

Parliament – including its committees, the individual members of Parliament, the Administration of Parliament and other institutions under Parliament – is outside the Ombudsman's jurisdiction. Thus, the Ombudsman is generally precluded from considering complaints regarding the isolated effects of a statutory provision or its compliance with the Constitution and international law. However, if any deficiencies in existing statutes or administrative regulations come to the Ombudsman's attention in specific cases, the Ombudsman must notify Parliament and the responsible minister. Further, the Ombudsman Act states that the Ombudsman must monitor that existing statutes and administrative regulations are consistent with, in particular, Denmark's international obligations to ensure the rights of children, including the UN Convention on the Rights of the Child.

Courts of justice are outside the Ombudsman's jurisdiction, and the same applies to court-like bodies and tribunals that make decisions on disputes between private parties. Subject to a few exceptions, the Ombudsman cannot consider complaints about private establishments either.

The Danish Parliamentary Ombudsman is located in Copenhagen and has no branch offices. The Faroe Islands and Greenland both

have their own ombudsman, with jurisdiction in relation to issues falling under the remit of the home rule administration in the case of the Faroe Islands and the self-government administration in Greenland's case. Issues relating to the Faroe Islands and Greenland which fall under the remit of central administrative authorities of the Realm of Denmark are within the jurisdiction of the Danish Parliamentary Ombudsman.

Working methods

The Ombudsman investigates complaints, opens investigations on his own initiative and carries out monitoring visits. Investigating complaints from citizens is a core function of the Ombudsman.

Complaint cases

In general, anybody can complain to the Ombudsman, also if they are not a party to a case. Complaining to the Ombudsman is free. A complainant cannot be anonymous.

The Ombudsman considers complaints about all parts of the public administration and in a limited number of situations also about private institutions, an example being complaints about conditions for children in private institutions.

The Ombudsman does not consider complaints about courts, nor about court-like bodies or tribunals which make decisions on disputes between private parties.

The Ombudsman's task is to ensure that the authorities have observed the applicable rules. For this reason, the Ombudsman cannot consider cases at first instance; he can consider a complaint only if the case has been considered by the relevant authority – and by any appeals bodies.

There is a deadline of one year for complaints to the Ombudsman.

When the Ombudsman receives a complaint, he first determines whether it offers sufficient cause for investigation. In some cases, the Ombudsman is unable to consider a complaint, whereas in other cases, he chooses not to open an investigation, for instance because he would not be able to help the complainant achieve a better outcome.

In a large proportion of complaint cases, the Ombudsman helps the citizen by providing guidance or by forwarding the complaint to the relevant authority, for instance in order that the authority will be able to consider the complaint or give the citizen more details of the grounds for a decision which it has made in the case.

In a number of cases, the Ombudsman discontinues his investigation because the authority chooses to reopen the case, for instance after being asked for a statement on the matter by the Ombudsman.

In some complaint cases, the Ombudsman carries out a full investigation, which, among other things, involves obtaining statements from the authority and the complainant. The investigation may result in the Ombudsman choosing to criticise the authority and, for instance, recommend that it make a new decision on the matter.

Own-initiative investigations

As mentioned above, investigating complaints from citizens is a core function of the Ombudsman. However, opening investigations on his own initiative is also a high priority for the Ombudsman.

The Ombudsman may open the following types of investigation on his own initiative:

- investigations of specific cases
- general investigations of an authority's processing of cases

An example of a topic for a general investigation could be whether an authority's interpretation and application of specific statutory provisions or its practice in a specific area is correct.

Objectives of own-initiative investigations
One of the main objectives of also giving high priority to own-initiative investigations is to identify recurring errors made by authorities. Investigations of this type can have a great impact on the case processing by authorities, thus helping a large number of citizens at the same time.

In an own-initiative investigation, the focus is not only on errors that the authority may already have made – but also on preventing errors being made in the first place.

In addition, the Ombudsman opens investigations on his own initiative of specific cases of a more one-off nature if he finds cause to look further into a case.

Backgrounds to opening own-initiative investigations
In practice, the Ombudsman mainly opens own-initiative investigations of themes and within areas with one or more of the following characteristics:

- There is an aspect of fundamental public importance.
- Serious or significant errors may have been made.
- They concern matters which raise important issues in relation to citizens' legal rights or are otherwise of great significance to citizens.

Specific complaint cases or monitoring visits may give rise to suspicion of recurring errors etc. and be the launch pad for an own-initiative investigation. When the Ombudsman is investigating a specific case, his focus is therefore, among other things, on problems which characterise not only that particular case.

Media coverage of a case may also cause the Ombudsman to open an investigation on his own initiative. The Ombudsman monitors both local and national media.

Further, external parties – such as professional committees for practising lawyers or accountants or interest groups – can be useful sources of knowledge about recurring errors etc. on the part of authorities.

In addition, the Ombudsman chooses some general themes each year for the activities of the Ombudsman's Monitoring Department, Children's Division and Taxation Division.

What characterises the work on own-initiative investigations?
The Ombudsman's own-initiative investigations comprise a variety of activities with the common denominator that they are not centred on a complaint in a specific case, as the focus is usually expanded beyond specific problems to a more general level, with emphasis on any general and recurring errors or problems.

Further, own-initiative investigations typically have a more forward-looking focus, centring on how the authorities involved can handle and rectify errors and problems.

In some own-initiative investigations, the Ombudsman reviews a number of specific cases from an authority.

In other cases, the Ombudsman asks an authority for a statement about, for instance, its administration, interpretation of the law, practice or processing times in a specific area.

The Ombudsman is working on an ongoing basis on a variety of own-initiative investigations where he considers, based on, for instance, specific complaint cases, legislative changes or media coverage, whether a matter should be investigated further. Thus, the Ombudsman decides on an ongoing basis which issues or areas give cause for investigation and how to prioritise them.

In some cases, the Ombudsman's own investigation leads to the conclusion that there is no cause to contact the authorities involved and that the case can thus be closed without a full Ombudsman investigation. The Ombudsman may also decide to close a case without a full investigation after contacting the authorities.

Monitoring visits

The Ombudsman carries out monitoring visits to places where there is a special need to ensure that citizens are treated with dignity and consideration and in accordance with their rights – because they are deprived of their liberty or otherwise in a vulnerable position.

Monitoring visits are made to a number of public and private institutions etc., such as:

- Prison and Probation Service institutions
- psychiatric wards
- social residential facilities
- residential institutions for children and young people

In addition, the Ombudsman monitors:

- forced deportations of foreign nationals
- forced deportations arranged by other EU member states at the request of the European Border and Coast Guard Agency, Frontex

Finally, the Ombudsman monitors the physical accessibility of public buildings, such as educational establishments, to persons with disabilities.

The Ombudsman's monitoring obligations follow from the Ombudsman Act and from the rules governing the following special responsibilities which the Ombudsman has been assigned:

- The Ombudsman has been designated 'National Preventive Mechanism' (NPM) under the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). 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.
- The Ombudsman monitors developments regarding equal treatment of persons with disabilities at the request of Parliament.
- The Ombudsman has been appointed to monitor forced deportations of foreign nationals.

A monitoring visit to an institution is normally a physical visit by a visiting team, who speak with users, staff and the management and look at the physical environment.

The monitoring of a forced deportation involves, among other things, a member of the Ombudsman's staff participating in the whole or part of the deportation.

Monitoring visits are carried out by the Ombudsman's Monitoring Department, except for visits to institutions etc. for children, which are carried out by the Children's Division.

External collaborative partners or consultants participate in a large proportion of visits. Depending on the type of monitoring visit, the Ombudsman collaborates with:

- medical doctors from DIGNITY – Danish Institute Against Torture
- human rights experts from the Danish Institute for Human Rights (IMR)
- wheelchair users from the Danish Association of the Physically Disabled
- consultants from the Danish Association of the Blind

During monitoring visits, the Ombudsman often makes 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 instance, degrading treatment.

In addition, monitoring visits may cause the Ombudsman to open own-initiative investigations of general problems.

Powers

Tools of investigation

Under the Ombudsman Act, the Ombudsman has a set of tools at his disposal when carrying out investigations. Firstly, authorities etc. within the Ombudsman's jurisdiction are required to furnish the Ombudsman with such information and to produce such documents etc. as he may demand. Secondly, the Ombudsman may demand written statements from authorities etc. within his jurisdiction. Thirdly, the Ombudsman may inspect authorities etc. within his jurisdiction and must be given access to all their premises.

Assessment and reaction

The Ombudsman's assessment of a case is a legal assessment. In connection with monitoring activities, however, the Ombudsman may also include universal human and humanitarian considerations in his assessment. The Ombudsman only considers the legal aspects of cases and not matters which require other specialist knowledge, such as medical matters. Further, the object of the Ombudsman's investigations is the acts or omissions of public authorities, not the acts or omissions of individual public servants.

Under the Ombudsman Act, the Ombudsman may express criticism, make recommendations and otherwise state his views of a case, typically by criticising a decision or recommending that the authority change or review its decision. The authorities are not legally obliged to comply with the Ombudsman's recommendations, but in practice, they follow his recommendations.

The Ombudsman may recommend that a complainant be granted free legal aid in connection with any matter within his jurisdiction.

If the Ombudsman's investigation of a case reveals that the public administration must be presumed to have committed errors or dereliction of major importance, he must notify Parliament's Legal Affairs Committee and the relevant minister or municipal or regional council.

Organisation

Under the Ombudsman Act, the Ombudsman engages and dismisses his own staff. The Ombudsman currently employs roughly 120 people, about 60 per cent of them law graduates.

The management of the institution consists of the Ombudsman, the Director General, the Deputy Director General and the Administrative Director. A management secretariat and an international section support the management.

The Ombudsman's office consists of two departments, a legal department and an administrative department, which are further divided into a number of divisions and units, respectively.

The Ombudsman's annual budget is approximately EUR 12 million.

2 General information about monitoring visits under the OPCAT mandate

In 2009 the Danish Parliament passed an amendment to the Ombudsman Act enabling the Ombudsman to act as National Preventive Mechanism (NPM) under the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). In the same year, the Ombudsman started carrying out the functions of the NPM.

Is the NPM independent?

The functions of the NPM are carried out as an integral part of the Ombudsman's work. The Ombudsman is independent of the executive power and is appointed by the Danish Parliament. The Ombudsman is independent of Parliament in the discharge of his functions.

Does the NPM have the necessary professional expertise?

The members of the Ombudsman's staff primarily have legal expertise. However, the Ombudsman's special advisor on children's issues participates in monitoring visits to institutions etc. for children. The Danish Institute for Human Rights contributes with human rights expertise, and DIGNITY – Danish Institute Against Torture contributes with medical expertise.

Does the NPM have the necessary financial resources?

The costs of exercising the functions of the NPM are financed via the overall Government appropriation for the Ombudsman.

Are monitoring visits carried out on a regular basis?

Approximately 30 monitoring visits to institutions for adults and 10 to 12 visits to institutions etc. for children are carried out per year.

What types of institutions are monitored?

The Ombudsman monitors, among others, the following types of institutions where adults may be deprived of their liberty:

State prisons are run by the Prison and Probation Service and receive convicted persons who are to serve a sentence. State prisons may be closed or open. Closed prisons are characterised by a high degree of security and control, whereas inmates in open prisons may be able to work or take part in training or education outside the prison. However, there are also clear limits to inmates' freedom of action in open prisons.

Local prisons are run by the Prison and Probation Service and receive arrestees, remand prisoners and in certain cases convicted persons

who are to serve a sentence. Local prisons are characterised by a high degree of security and control.

Halfway houses are run by the Prison and Probation Service and are used especially for the rehabilitation of convicted persons who are serving the last part of their sentence. Compared to prisons, halfway houses may have a high degree of freedom.

Immigration detention centres are run by the Prison and Probation Service and receive foreign nationals who are to be detained, as a general rule not for a criminal offence but for reasons relating to the Aliens Act.

Departure centres are run by the Prison and Probation Service and receive rejected asylum seekers, persons sentenced to deportation and persons with tolerated residence status. The residents are not under detention and are therefore free to come and go. As a general rule, however, they are required to reside at the centre, including to spend the nights there.

Asylum centres are run by municipalities and the Danish Red Cross and comprise, among others, reception centres, where asylum seekers stay the first weeks after arrival, and residential centres, where they stay while the authorities are considering their application for asylum.

Police detention facilities are used to detain persons who are unable to take care of themselves, for instance due to intoxication.

Police custody reception areas are used for detentions of very short duration without overnight stays of arrestees.

Psychiatric wards are run by the regions and receive psychiatric patients. Wards may be open (with unlocked outer doors), closed (with locked outer doors) or integrated (with outer doors or doors to certain sections being locked according to patients' needs). There are also forensic psychiatric wards, which receive, among others, patients sentenced to placement or treatment in a psychiatric ward.

Social residential facilities are run by regions, municipalities or private parties and receive persons with impaired cognitive or physical functioning. In addition, they receive persons sentenced to placement in a social residential facility. Outer doors are unlocked, except in secure units.

Care homes are run by municipalities or private parties and receive persons with an extensive need for personal care, healthcare and extra support in their daily lives.

The Ombudsman monitors, among others, the following types of institutions etc. where children and young people may be placed:

Open residential institutions are run by municipalities or regions and receive children and young people belonging to the target group for which the institution has been approved. The target group may be defined in terms of age but may also be defined in terms of needs, diagnoses or disabilities.

Partly closed residential institutions and partly closed units of residential institutions are run by municipalities or regions and receive children and young people with criminal behaviour, substance abuse or other behavioural problems. In these institutions and units, residents may be detained by periodic locking of windows and outer doors.

Secure residential institutions and high secure units of residential institutions are run by municipalities or regions and receive children and young people in order to prevent them harming themselves or others or for observation or treatment. These institutions and units may also receive, among others, young people to be remanded in non-prison custody during investigation of their case or convicted young people who are to serve a sentence. Windows and outer doors may be constantly locked, and placements of short duration in a seclusion room are permitted.

Accommodation facilities are run by private parties, such as foundations or enterprises, and receive children and young people belonging to the target group for which the facility has been approved.

Foster families are either general, reinforced, specialised or network foster families. A foster family may foster children and young people belonging to the target group for which it has been approved. Reinforced foster families may foster children and young people with moderate to high support needs, whereas specialised foster families may foster children and young people with high support needs.

24-hour units of child and adolescent psychiatric wards are run by the regions and receive children and young people for examination or treatment of psychiatric disorders.

Asylum centres for unaccompanied underage asylum seekers are run by municipalities and the Danish Red Cross and are residential centres where unaccompanied underage asylum seekers stay while the authorities are considering their application for asylum.

How are monitoring visits carried out?

A monitoring visit is typically a physical visit. Before or following the visit, the Ombudsman will ask for various information, for instance reports of incidents involving use of force, records of statements taken prior to the sanction of placement in a disciplinary cell being imposed, or information from parents or other relatives. During the visit, the Ombudsman's visiting team will speak with users, staff and the management.

The Ombudsman has designated the following general focus areas for his monitoring visits:

- use of force and other restrictions
- interpersonal relations
- work, education and leisure time
- health-related issues
- user safety
- sector transfers

The prioritisation of the individual focus areas depends on the place visited. During specific monitoring visits, the Ombudsman may also focus on other issues, for instance buildings in a poor state of repair.

In most cases, recommendations are made to the management of the institution already during the monitoring visit.

Following the visit, the visiting team will prepare a memorandum of the visit, and the Ombudsman will subsequently send a concluding letter to the institution and the responsible authorities with his recommendations.

DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights normally take part in preparing, carrying out and following up on the monitoring visits.

Each year, the Ombudsman chooses, together with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights, one or more themes for the year's monitoring visits. The majority of the monitoring visits to be carried out during the year will be to institutions where the themes will be relevant. A theme could be, for instance, disciplinary cells or younger children placed in social care.

After the monitoring visits for a given year have been carried out, the Ombudsman prepares a separate report on the year's work in relation to each of the themes for the Ombudsman's monitoring visits to institutions for adults and children. The reports summarise and present the most important results in relation to the themes. Results may be general recommendations to the responsible authorities, for instance a recommendation to see that institutions draw up policies on prevention of violence and threats among residents. The reports are also used as a starting point for discussions with key authorities about general problems.

Monitoring visits may cause the Ombudsman to open cases on his own initiative, with, among others, the authorities which have the remit for the relevant areas. This may be the case, for instance, with general problems which affect not only the specific institution visited. An example of such a case opened on the Ombudsman's own initiative was an investigation of whether it was permitted to initiate various types of measures in relation to psychiatric patients without statutory authority.

Does the Ombudsman submit proposals and observations regarding existing legislation or drafts for legislation?

The Ombudsman monitors that the authorities observe the conventions within the framework of Danish legislation.

The more politico-legal and advisory tasks in relation to the legislature are carried out by other bodies, such as the Ombudsman's collaborative partners in the discharge of his functions as NPM (i.e. the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture). According to an established practice, the Ombudsman does not submit consultation responses on bills, with the exception of bills affecting matters which relate to the Ombudsman's office itself.

The Ombudsman may notify the responsible minister and Parliament if a statute or the state of the law in a specific area is not consistent with Denmark's international obligations and a legislative change may therefore be required.