FOLKETINGETS OMBUDSMAND

Annual Report 2021

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 2021 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:

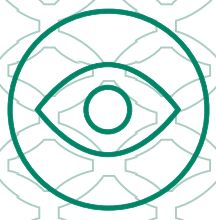
Part One: Extract of the pages from the international edition of the Danish Parliamentary Ombudsman's Annual Report 2021 which relate specifically to the Ombudsman's monitoring activities according to the OPCAT-protocol. The extracted material is unchanged from the Annual Report, and the original pagination has been maintained.

Part Two: Overview 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 2021. The thematic report regarding adults concerns force and non-statutory interventions in the psychiatric sector. The thematic report regarding children concerns children and young people in secure residential institutions.

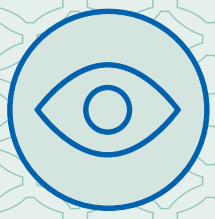
Part Four: An appendix from the Annual Report about the Ombudsman and monitoring visits under the OPCAT mandate.

All the above-mentioned material is also available on www.en.ombudsmanden.dk, including the Annual Report 2021 in full.



Part One

Extract from the Danish Parliamentary Ombudsman's Annual Report 2021



Monitoring activities

Where: The Ombudsman carries out monitoring visits to places where there is a special need to ensure that the authorities treat citizens 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, 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, for persons with disabilities.

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

- The Ombudsman carries out monitoring visits in accordance with Section 18 of the Ombudsman Act, especially to institutions where citizens are deprived of their liberty.
- 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 monitoring team, who speak with users, staff and management and look at the physical environment. In 2021, 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 visited institutions and to the responsible authorities. Issues arising 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.

Who: Monitoring visits are carried out by the Ombudsman's Monitoring Department, except for visits to institutions 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 2021?

Monitoring visits – adults

9 Prison and Probation Service institutions, including 6 in Greenland

- 5 physical visits
- 4 virtual visits

10 psychiatric wards

- 7 physical visits
- 3 virtual visits

14 police authorities in Greenland, including 10 detention facilities

- 10 physical visits
- 2 virtual visits
- 1 partial phone visit and 1 phone visit

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

Monitoring visits – children

1 open residential institution

1 physical visit

8 secure residential institutions, including 2 with special secure units

2 physical visits

6 virtual visits

Themes

Theme in 2021 – adults

Force and non-statutory interventions in the psychiatric sector
In 2021, the Ombudsman's focus was on force pursuant to the Danish Mental Health Act and non-statutory measures and interventions in the psychiatric sector.

The Mental Health Act includes a number of provisions regarding the use of force against patients who are hospitalised in a psychiatric ward. This can consist of for instance forced immobilisation, compulsory medication and manual restraint.

In addition to the above, non-statutory measures and interventions towards patients can be implemented. This can be for instance 'shielding in own room' where a patient gives consent to remain in his or her own room for a period.

The Ombudsman visited selected units in ten psychiatric wards in total. Three of the visits were conducted virtually due to COVID-19. In addition, one planned visit was cancelled due to COVID-19.

Focus areas
During the thematic visits in 2021, the visiting teams focused particularly on the following questions:

- Do the psychiatric wards work on preventing and reducing the use of force?
- Do the psychiatric wards work on ensuring that the conditions for using force are observed?
- Is there documentation that the conditions for using force have been observed?
- Is there the necessary legal basis for non-statutory measures and interventions?
- How is consent for non-statutory measures and interventions obtained and documented?

Examples of recommendations
In connection with the visits, a number of recommendations were given on subjects within the theme of the year – for instance, the Ombudsman recommended that the wards' management ensure

- focus on preventing and reducing the use of force
- focus on precise and adequate documentation in records on forced immobilisation
- that house rules and practice were reviewed and adjusted so that restrictive measures are not instituted without the patient's consent or required legal basis
- that consent for non-statutory restrictive measures is obtained and documented in accordance with applicable rules and practice.

Read about themes at en.ombudsmanden.dk/themes

Follow-up
The visits have given the Ombudsman cause to raise an own-initiative case against the Ministry of Health regarding the use of private guards.

A thematic report will be published in 2022 that summarises the main conclusions of the thematic visits. In addition, the thematic report will contain the Ombudsman's general recommendations based on the monitoring visits.

Theme in 2021 – children

Children and young people in secure residential institutions
The Ombudsman's thematic visits in 2021 were aimed at children and young people in secure residential institutions.

As part of the theme, the Ombudsman visited all eight secure residential institutions in Denmark, of which two also had high secure units. At the same time, the Ombudsman visited the institutions' in-house schools.

Six of the eight visits were carried out as virtual visits due to COVID-19.

Focus areas
During the thematic visits in 2021, the monitoring teams focused particularly on

- use of physical force
- solitary confinement
- house rules, body searching, search of living spaces, and drug testing
- education in in-house schools

Examples of recommendations
In connection with the visits, a number of recommendations were made on matters related to the year's theme. For instance, the Ombudsman recommended that the institutions

- observe deadlines for recording and reporting use of force etc.
- ensure that parents are informed of their rights in relation to the use of force and other interventions
- ensure that staff know who can decide to place a child or young person in solitary confinement
- observe the rules on teaching the full range of subjects and class hours and on exemption from lessons in subjects and sitting tests and examinations
- ensure that children and young people are offered to be screened in order to uncover any need for psychiatric examination
- increase their attention on identifying young people at risk of developing withdrawal symptoms and ensure treatment.

A thematic report will be published in 2022 that summarises the main conclusions of the thematic visits. In addition, the thematic report will contain the Ombudsman's general recommendations based on the monitoring visits.

Ensuring legal authority for interventions in the psychiatric sector

Legislative amendment: On 21 December 2021, Parliament adopted to amend the Mental Health Act based on an Ombudsman investigation, among other things. One of the purposes of the amendment is to ensure a more clear legal basis for certain interventions in the psychiatric sector.

The Ombudsman's investigation led to the Ministry of Health and Senior Citizens agreeing that there could be a need for a more clear legal basis.

In connection with monitoring visits to closed psychiatric wards, which the Parliamentary Ombudsman carried out in 2019 and 2020, the Ombudsman became aware of a recurring problem, which gave occasion for an own-initiative investigation. Many of the wards had house rules containing rules about interventions towards the patients, where it could be doubtful whether the necessary legal authority existed.

The Ombudsman's investigation led to the Ministry of Health and Senior Citizens agreeing that there could be a need for a more clear legal basis. On this background, the Ministry stated that it would work towards the legislative amendment that has now been adopted.

Residents in social residential facilities were kept under surveillance

Legal authority: In the course of several monitoring visits in 2020 – where the Ombudsman had a special focus on conditions for convicted persons with intellectual and developmental disabilities – the visiting team became aware that some social residential facilities were or had been surveilling residents placed in the facility according to a sen tence in order to ensure that the residents stayed within the confines of the facility. This gave rise to an own initiative investigation on the authority to generally surveil convicted residents in social res idential facilities.

The Ombudsman agreed with the Ministry of Social Affairs and Senior Citizens that there is no legal authority for a social residential facility – in order to prevent escape – to generally surveil residents in living areas at the sole disposal of the individual resident by gaining access to the resi dent 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.

Cots and locking systems at residential institutions

Right of self-determination: It affects children and young people considerably when institutions where they live establish physical settings that restrict the possibility of free movement. During monitoring visits, the Ombudsman therefore checks if the use of force and other interventions in children and young people's right to self-determination are legal and proportional.

At a visit to an open residential institution for children and young people with physical or mental disabilities, the Ombudsman became aware of two matters of a physical nature that involved restriction of free movement:

- Some of the children slept in cots (beds with high sides or locking systems), which prevented them from leaving the beds on their own.
- Some of the outer doors had a locking system with a double handle and a delayed opening mechanism, which made it difficult for some children to open the doors.

The Ombudsman asked the Ministry of Social Affairs and Senior Citizens to determine if there was legal authority to use such beds and locking systems and, if so, to what extent.

> **The locking systems on the outer doors were also not regulated in the Adult Responsibility Act or the Social Services Act.**

The Ministry replied that the Adult Responsibility Act and the Social Services Act do not specifically regulate the use of cots. But it was the Ministry's assessment that cots with high sides could be used to protect infants and young children against harming themselves by falling out of bed. The use for this group of children was thus justified.

If, on the other hand, the beds were used for older children, it was, as a principal rule, not justified. However, subject to a specific assessment, there may be exceptions in relation to children and young people with physical or mental disabilities.

The locking systems on the outer doors were also not regulated in the Adult Responsibility Act or the Social Services Act. The Ministry stated that at a residential institution with younger children a locking system could be used to ensure that the children do not inadvertently walk into streets or parking areas, thus bringing themselves in danger. However, this presupposes that the children can open other outer doors, for instance to a garden.

If the locking system also prevented older children from going out freely, it would be an intervention in the form of use of force, thus requiring separate legal authority.

The municipality (and the residential institution) agreed with the Ministry's reply. The Ombudsman found that the authorities' statement was convincing and did not take the matter any further.

Children's legal position should be clearer

The Adult Responsibility Act: When staff in accommodation facilities and residential insti tutions use force towards children and young people, it must be done within the scope set out in legislation. Often – but not always – the rules of the Adult Responsibility Act apply. Based on a number of monitoring visits, the Ombudsman opened a case against the Ministry of Social Af fairs and Senior Citizens in order to clarify the scope of the Adult Responsibility Act in accom modation facilities and residential institutions as well as in house schools.

There are different protocols for use of force towards children and young people, depending on where they live and go to school. This makes great demands on staff.

On the basis of the case, the Ombudsman found that there are different protocols for use of force etc. towards children and young people, depend ing on where they live and go to school. This makes great demands on staff who, in addition to knowing the rules, must also know specifically where each child or young person lives or is placed,

The Ombudsman therefore stated that he as sumed that the Ministry would include the issues in the Ministry s work with clarifying the legal position in this area.

Who helps convicted persons with intellectual and developmental disabilities to achieve a life without crime?

Franz Amdi Hansen
Legal Case Officer

Morten Engberg
Senior Head of Department

The Ombudsman reviewed the rules on municipalities' crime prevention supervision of convicted persons with intellectual and developmental disabilities. The review showed that the supervisory obligation did not include the persons who are subject to the most extensive restrictions.

'The defendant', it says on the last page of the judgment, 'shall be placed in an institution for persons with substantial mental disabilities so that she may be transferred to a secure unit, subject to decision by the municipality.

No maximum duration for the measure is stipulated.'

This could be a judgment in a case where a defendant with an intellectual and developmental disability has been charged with a criminal offence. Because although the Criminal Code says that persons with mental disabilities cannot in certain circumstances be given a prison sentence, they can instead be sentenced to so-called preventive measures.

Convicted persons with intellectual and developmental disabilities are subject to a complicated set of rules that allows restrictions of basic rights. This is also a group of persons who in many instances have difficulty in understanding how they are entitled to be treated and when they can make a complaint. This is why the Ombudsman chose conditions for this group of persons as the theme for his monitoring visits to institutions for adults in 2020.

Is it the municipalities' responsibility to help?

In connection with his preparation for the theme, the Ombudsman reviewed, among other things, who has the responsibility for helping the convicted persons to achieve a life without crime. The risk of the convicted persons committing new offences will thus often determine whether a preventive measures sentence is modified or terminated.

The Ombudsman's thematic report 2020 on convicted persons with intellectual and developmental disabilities is available in Danish and English on the Ombudsman's website. The report includes the recommendations that the Ombudsman has given to the 17 social residential facilities for convicted persons with intellectual and developmental disabilities that he visited in 2020, and his recommendations to the responsible ministries.

Briefly on preventive measures sentences

A preventive measures sentence (in Danish, 'foranstaltningsdom') can mean that the convicted person is sentenced to placement in a social residential facility or a secure unit.

The sentence can also stipulate that a municipality can later decide that it is necessary to transfer the convicted person to a secure unit.

A person sentenced to placement in a social residential facility or a secure unit is deprived of his or her liberty. The person must therefore have special permission in order to leave the institution's premises.

Preventive measures sentences can be either with or without **maximum duration**.

- Preventive measures **with** maximum duration can be extended.
- At intervals of a few years, an assessment must be made whether to terminate preventive measures **without** maximum duration.
- The measures must not remain in force for longer or more extensively than necessary.

The review was due to the consideration that if sufficient crime prevention measures are not implemented for convicted persons with intellectual and developmental disabilities, these persons can end up being deprived of their liberty for longer than if targeted measures are put in place in order to prevent new offences being committed.

Section 16 a of the Consolidation Act on Legal Protection and Administration in Social Matters stipulates that municipalities 'shall, for crime prevention purposes, supervise persons who, under a judgment or order or under terms for dismissal of charges or probation, must be subjected to supervision by social authorities'.

The Ombudsman therefore asked two questions of the, then, Ministry of Social Affairs and the Interior (and subsequently also of the present Ministry of Social Affairs and Senior Citizens) concerning the role of the municipalities.

Do municipalities have an obligation to carry out crime prevention supervision of persons who have been sentenced to placement in an institution?
According to its wording, Section 16 a of the Consolidation Act on Legal Protection and Administration in Social Matters includes persons sentenced to be subjected to supervision – however, the prosecution service does not normally ask the court to decide that the convicted person shall both be subjected to supervision and be placed in an institution.

This means that, normally, persons sentenced to placement in a social residential facility or a secure unit are not also sentenced to be subjected to supervision. Does this mean that municipalities are not obliged to carry out crime prevention supervision of those convicted persons with intellectual and developmental disabilities? – the Ombudsman asked.

The Ministry replied that the wording of Section 16 a of the Consolidation Act on Legal Protection and Administration in Social Matters presupposes that the obligation to carry out crime prevention supervision only applies if a sentence or decision has stipulated that a person is to be subjected to supervision by social authorities. By contrast, in the Ministry's opinion there will not be an obligation to carry out crime prevention supervision if it has only been decided that a person is to be placed in an institution.

At the same time, the Ministry pointed out that persons placed in an institution will be subjected to the residential municipality's individually targeted supervision according to the Social Services Act, and that they will also be in contact with the social residential facility staff.

What does the obligation to carry out crime prevention supervision imply?
Section 16 a of the Consolidation Act on Legal Protection and Administration in Social Matters does not specify what the municipalities' crime prevention supervision implies. However, it did appear from a handbook from the National Board of Social Services on charged and convicted citizens with intellectual and developmental disabilities that Section 16 a can task municipalities with implementing crime prevention measures. The Ombudsman asked the Ministry whether this was how the municipalities' obligation was to be understood.

The Ministry replied that Section 16 a of the Consolidation Act on Legal Protection and Administration in Social Matters does not – despite what appears from the handbook – impose upon the municipalities an obligation to implement crime prevention measures. However, the Ministry said, based on the provisions in, among others, the Social Services Act, the municipalities could be obligated to implement socio-educational measures that could also have a crime-preventive effect.

The Ombudsman concluded that he could not disregard the perception of the municipalities' obligations according to Section 16 a of the Consolidation Act on Legal Protection and Administration in Social Matters that the Ministry of Social Affairs and the Interior and later the Ministry of Social Affairs and Senior Citizens had presented, as it could be included within the wording of the provision.

Overall, this means that the scope of Section 16 a is quite limited:

- It does not include those persons with intellectual and developmental disabilities who have been sentenced to placement in an institution, and thereby only includes those who are subject to the least restrictive measures.
- It does not impose upon the municipalities an obligation to implement crime prevention measures towards persons included in the provision.

But you could ask whether the legislative power had been aware of and considered the suitability of these legal conditions when Section 16 a of the Consolidation Act on Legal Protection and Administration in Social Matters was passed.

The Ombudsman therefore provided information about the case to the Ministry of Social Affairs and Senior Citizens as well as Parliament's Legal Affairs Committee and Social Affairs and Senior Citizens Committee.

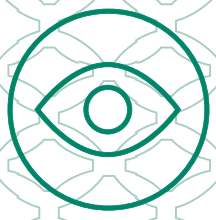
The case has been published on the Ombudsman's website as Case No. 2021-23 (in Danish only).

The Ombudsman's monitoring visits

During 2020, as part of the theme for monitoring visits to institutions for adults, the Ombudsman visited 17 social residential facilities housing convicted persons with intellectual and developmental disabilities.

The Ombudsman's monitoring visits were carried out in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture. Consequently, the monitoring teams carrying out the visits consisted of staff from both the Ombudsman Office and the two institutes.

The visits showed that many social residential facilities made a considerable socio-educational effort towards the residents, including residents with a preventive measures sentence. The Ombudsman was cautious of assessing this effort in more detail since he and his legal case officers do not have the professional qualifications for making an assessment of socio-educational measures, including whether the measures can have a crime-preventive effect. However, based on information received from the social residential facilities, the Ombudsman considered that the implemented measures could also have a crime-preventive effect – but he noted that in many instances the social residential facilities had not determined the concrete socio-educational targets that needed to be achieved in order to prevent new offences being committed.



Part Two

Overview of factual information regarding the individual monitoring visits and recommendations

Overview: Monitoring visits to institutions for adults in 2021

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). Lastly, the table shows the recommendations given to the individual institution. Un-der the OPCAT[1], the Ombudsman collaborates with DIGNITY – Danish In-stitute Against Torture and the Danish Institute for Human Rights (IMR), which participate in monitoring visits, among other things. At the time of the monitoring visits in Greenland, the Ombudsman's OPCAT mandate did not apply in relation to Greenland, and therefore IMR and DIGNITY did not partic-ipate in the visits in Greenland.

[1] OHCHR | Optional Protocol to the Convention against Torture (OPCAT)

MONITORING VISITS	NO. OF VISITS
NO. OF VISITS	33
TALKS WITH USERS	126
TALKS WITH RELATIVES ETC.	68
WITH DIGNITY	13
WITH IMR	9
ANNOUNCED/UNANNOUNCED VISITS	33/0
PHYSICAL/VIRTUAL/PHONE/PARTIAL PHONE VISITS	22/9/1/1
CONCLUDED WITH RECOMMENDATIONS	33
CONCLUDED WITHOUT RECOMMENDATIONS	0

MONITORING VISITS

Mental Health Services in the Region of Southern Denmark, Esbjerg Psychiatric Hospital
23 February
Two integrated bed units for general and forensic psychiatric patients
Talks with 3 users and 10 relatives
DIGNITY and IMR participated

Recommendations

- that management ensure that offered and held follow-up interviews are documented in accordance with applicable rules

- that management ensure continued focus on preventing and reducing use of force

- that management ensure that the internal guidelines on when forced immobilisation is to be terminated are in accordance with the relevant applicable rules and practice

- that management ensure that the name(s) of the involved staff appear(s) from the protocols on use of force

- that management ensure that information on all types of interventions used appear from the protocol on use of force

- that management ensure focus on precise and comprehensive documentation in records about forced immobilisation, including
    - stating precise and comprehensive grounds for initiating and maintaining belt restraint, which – in connection with restraint for longer than a few hours – observe the more rigorous requirements set out in Section 14(3) of the Mental Health Act
    - stating separate grounds for initiating and maintaining restraint with straps

- that management ensure that it is assessed as soon as possible whether a patient's restraints can be loosened when an external doctor has assessed that there are no longer grounds for restraining the patient

- that management ensure new medical assessment of the need for continued forced immobilisation at least three times a day at regular intervals

- that management ensure that records about forced immobilisation state that external medical examinations under Section 21(5)-(7) of the Mental Health Act have been carried out by a doctor who is not employed in the psychiatric unit where the intervention takes place

- that management ensure that house rules and practice are reviewed and adjusted in accordance with the Ministry of Health's statements most recently forwarded from Danish Regions to the regions on 26 March 2021, so that no extensive measures are carried out without the patients' consent or clear legal authority with respect to restriction of the patients' access to a mobile phone

- that management ensure that consent to extensive measures is obtained and documented in accordance with the relevant applicable rules and practice

Mental Health Services in the Region of Southern Denmark, Middelfart Forensic Psychiatric Hospital
25 February
Two closed bed units for forensic psychiatric patients
Talks with 10 users and 5 relatives
DIGNITY and IMR participated

Recommendations

- that management ensure continued focus on offering follow-up interviews in accordance with the applicable rules and on documenting offered follow-up interviews, including the reason that offered follow-up interviews are not carried out

- that management ensure continued focus on preventing and reducing use of force

- that management ensure that the staff have been instructed in the care staff's access to terminate forced immobilisation when it is no longer necessary to maintain it, cf. Section 16(10) of Executive Order No. 1075 of 27 October 2019

- that management ensure that the internal guidelines on when forced immobilisation is to be terminated are in accordance with the relevant applicable rules and practice

- that management ensure that protocols on use of force are in accordance with the applicable rules and that they contain information on
    - any disagreement between the external doctor and the attending doctor

    - the name of the prescribing doctor
    - name(s) of the involved staff
    - the name of the doctor who carried out the new medical assessment

- that management ensure new medical assessment of the need for continued forced immobilisation at least three times a day at regular intervals

- that management ensure focus on precise and comprehensive documentation in records about forced immobilisation, including
    - stating precise and comprehensive grounds for initiating and maintaining belt restraint, which – in connection with restraint for longer than a few hours – observe the more rigorous requirements set out in Section 14(3) of the Mental Health Act
    - stating separate grounds for initiating and maintaining restraint with straps

- that management ensure that house rules and practice are reviewed and adjusted in accordance with the Ministry of Health's statements most recently forwarded from Danish Regions to the regions on 26 March 2021, so that no extensive measures are carried out without the patients' consent or clear legal authority with respect to
    - restriction of the patients' use of a mobile phone and PC
    - restriction of the patients' access to visits
- that management ensure that practice concerning the opening and checking of the patients' mail reflect the applicable rules, including the condition of suspicion, cf. Section 19 a of the Mental Health Act
- that management ensure that no interventions are carried out without the patients' consent with respect to shielding in own room
- that management ensure that consent to shielding in own room and other extensive measures is obtained and documented in accordance with the relevant applicable rules and practice

Mental Health Services in the Capital Region of Denmark, Psychiatric Center Glostrup
10 and 11 March
Two closed emergency 24-hour units, one closed forensic psychiatric unit and one integrated intensive 24-hour unit
Talks with 9 users and 8 relatives
DIGNITY and IMR participated

Recommendations

- that management ensure continued focus on documenting held follow-up interviews in accordance with the applicable rules and on documenting offered follow-up interviews, including the reason that offered follow-up interviews are not carried out
- that management ensure continued focus on preventing and reducing use of force
- that management ensure that the staff have been instructed in the care staff's access to terminate forced immobilisation when it is no longer necessary to maintain it, cf. Section 16(10) of Executive Order No. 1075 of 27 October 2019
- that management ensure new medical assessment of the need for continued forced immobilisation at least three times a day at regular intervals
- that management ensure focus on precise and comprehensive documentation in records about forced immobilisation, including stating precise and comprehensive grounds for maintaining belt restraint, which – in connection with restraint for longer than a few hours – observe the more rigorous requirements set out in Section 14(3) of the Mental Health Act
- that management ensure that house rules and practice are reviewed and adjusted in accordance with the Ministry of Health's statements most recently forwarded from Danish Regions to the regions on 26 March 2021, so that no extensive measures are carried out without the patients' consent or clear legal authority with respect to
    - restriction of the patients' access to a mobile phone and PC
    - restriction of the patients' access to sexual intercourse with each other
- that management ensure that practice concerning search of belongings and body searching reflects the applicable rules, including the condition of suspicion, cf. Section 19 a of the Mental Health Act
- that management ensure that no interventions are carried out without the patients' consent with respect to shielding in own room, other area restrictions or washing of clothes upon suspicion of drugs

- that management ensure that consent to shielding in own room and other extensive measures is obtained and documented in accordance with the relevant applicable rules and practice

The State Prison of Kragskovhede
17 and 20 May
Two open wards
Talks with 10 users
DIGNITY and IMR participated

Recommendations

- that management ensure that the instructions on handling inmates refusing to work and expelled inmates, which were being drafted at the time of the monitoring visit, will include a maximum number of inmates that can be placed in the work refusal room at the same time
- that management ensure that it is checked whether there is legal authority for video surveillance in the work refusal room and what conditions must be met, including what information about the surveillance that inmates placed in the work refusal room must be given
- that management ensure that the prison's practice of placing inmates subject to increased monitoring in a solitary confinement cell is in accordance with the rules on exclusion from association, including the rules on placement in an observation cell
- that management ensure that a policy is drafted about handling violence and threats among the inmates, which should include registration and follow-up of episodes, including follow-up of non-specified information about threats and violence among inmates

Own-initiative case opened against the Department of Prisons and Probation concerning dental treatment

The Prison and Probation Service in Kolding, 'Pension Lyng'
2 June
Half-way house under the Prison and Probation Service, especially for convicted persons who are serving the last part of their sentence or are under supervision
Talks with 4 users
DIGNITY participated

Recommendations

- that management ensure increased attention on the handling of mentally vulnerable inmates, including that management ensure supplementary training of the staff or in another way instructs the staff in what to keep an eye on and how the staff should handle this type of inmates

- that management, in cooperation with the nurses, endeavour to uncover whether there are unreported figures in relation to violence and threats among inmates

Own-initiative case opened against the Department of Prisons and Probation concerning dental treatment

Mental Health Services in the Capital Region of Denmark, Psychiatric Center Copenhagen (Bispebjerg)
25 August
Emergency admission

Talks with 2 users and 2 relatives
DIGNITY and IMR participated

Recommendations

- that management ensure continued focus on short-term restraint only taking place after a specific assessment, where the patient's advance statement is considered, including that the action card about the emergency patient is in accordance with guideline No. 9552 of 10 August 2020

- that management ensure that long-term restraint lasting more than 30 minutes is avoided

- that management ensure focus on precise and comprehensive documentation in records about forced immobilisation, including stating precise and comprehensive grounds for maintaining belt restraint, which – in connection with restraint for longer than a few hours – observe the more rigorous requirements set out in Section 14(3) of the Mental Health Act

- that management ensure new medical assessment of the need for continued forced immobilisation at least three times a day at regular intervals

- that management ensure that, in connection with long-term restraint, external medical examinations are made in accordance with Section 21(5)-(7) of the Mental Health Act

- that management ensure that the written house rules are handed out to the patients on admission, cf. Section 2a(2) of the Mental Health Act

- that management ensure that practice is reviewed and adjusted in accordance with the Ministry of Health's statements most recently forwarded from Danish Regions to the regions on 26 March 2021, so that no extensive measures are carried out without the patients' consent or clear legal authority with respect to a ban or restriction of the patients' access to a mobile phone etc.

- that management ensure that practice concerning search of belongings and body searching reflects the applicable rules, including the condition of suspicion, cf. Section 19 a of the Mental Health Act

- that management ensure that no interventions are carried out without the patients' consent with respect to shielding in own room

- that management ensure that consent to shielding in own room and other extensive measures is obtained and documented in accordance with the relevant applicable rules and practice

Mental Health Services in the North Denmark Region, Frederikshavn Psychiatric Hospital
8 September
One open bed unit for general and forensic psychiatric patients
Talks with 4 users and 1 relative
DIGNITY participated

Recommendations

- that management ensure that house rules and practice are in accordance with applicable law

- that management ensure that consent to shielding in own room is documented in accordance with the relevant applicable rules and practice

Mental Health Services in Region Zealand, 'Sikringen'
13-14 September
Secure ward with three identical units
Talks with 11 users and 18 relatives
DIGNITY and IMR participated

Recommendations

- that management ensure that valid and current figures for use of force are available at all times

- that management ensure that long-term restraint lasting more than 30 minutes is avoided, and that management systematically follow up on the development in the number of long-term restraints

- that management – to the extent deemed relevant – bring up questions in relevant professional forums about access to forced medication of patients, and consider informing relevant authorities about it
- that management consider if there are grounds for setting specific objectives for reducing use of force

- that management ensure focus on precise and comprehensive documentation in records about forced immobilisation, including stating precise and comprehensive grounds for maintaining belt restraint,

which – in connection with restraint for longer than a few hours – observe the more rigorous requirements set out in Section 14(3) of the Mental Health Act, as well as separate grounds for initiating and maintaining restraint with straps
- that management ensure that follow-up interviews are offered and documented in accordance with applicable rules
- that management ensure that house rules and practice are in accordance with applicable law, including
    - that the wording in the house rules and practice on opening patients' mail reflects the applicable rules, including the condition of suspicion, cf. Section 19 a of the Mental Health Act
    - that the wording in the house rules on monitoring of locked-in patients at night reflects the rules of Section 30(2) of the executive order on use of other kinds of force than deprivation of liberty in psychiatric wards

- that management ensure that a concrete assessment is made in each individual case whether a newly arrived patient meets the conditions for door locking, cf. Section 18 a of the Mental Health Act

- that management consider if the restraint measures fixed to the bed in the 0-room (zero room or zero stimulus room) can be removed when a patient is in the room under Section 18 a of the Mental Health Act

Mental Health Services in the Central Denmark Region, Horsens Psychiatric Hospital
15 September
One closed bed unit and Psychiatric Admission
Talks with 3 users and 5 relatives
DIGNITY and IMR participated

Recommendations
- that management ensure new medical assessment of the need for continued forced immobilisation at least three times a day at regular intervals

- that management ensure focus on precise and comprehensive documentation in records about forced immobilisation, including stating precise and comprehensive grounds for maintaining belt restraint, which – in connection with restraint for longer than a few hours – observe the more rigorous requirements set out in Section 14(3) of the Mental Health Act

- that management ensure that no interventions are carried out without the patients' consent with respect to shielding in own room

- that management ensure that consent to shielding in own room is obtained and documented in accordance with the relevant applicable rules and practice

Mental Health Services in the Central Denmark Region, Viborg Psychiatric Hospital
22-23 September
One intensive bed unit, one bed unit, one forensic psychiatric unit and one unit for special care beds
Talks with 23 users and 10 relatives
DIGNITY participated

Recommendations

- that management ensure that the staff's understanding of the reasons for and purpose of forced immobilisation is reflected in minutes of follow-up interviews, and that follow-up interviews are documented in the correct place in the records
- that management ensure that long-term restraint lasting more than 30 minutes is avoided
- that management ensure continued focus on preventing and reducing use of force
- that management ensure systematic follow-up of overrulings by the Psychiatric Patients' Board of Appeal, and that the staff is made aware of the practice

- that management ensure that the name(s) of the involved staff appear(s) from the protocols on use of force

- that management ensure new medical assessment of the need for continued forced immobilisation in accordance with the applicable rules

- that management ensure focus on precise and comprehensive documentation in records about forced immobilisation, including stating precise and comprehensive grounds for maintaining belt restraint, which – in connection with restraint for longer than a few hours – observe the more rigorous requirements set out in Section 14(3) of the Mental Health Act

- that management ensure that house rules and practice are in accordance with applicable law, including that the wording of the house rules and practice on search of patients' belongings and body

searching reflects the condition of suspicion in Section 19 a of the Mental Health Act

- that management ensure that no shielding in own room is carried out without the patient's consent, and that the house rules on shielding in own room are changed so that it is clear that such interventions cannot be carried out without the patient's consent
- that management ensure that consent to shielding in own room is documented in accordance with the relevant applicable rules and practice

Mental Health Services in the North Denmark Region, Aalborg Psychiatric Hospital
6-7 October
Two general psychiatric bed units and two forensic psychiatric bed units
Talks with 8 users and 4 relatives
DIGNITY participated

Recommendations

- that management ensure continued focus on preventing and reducing use of force

- that management ensure that the name(s) of the involved staff appear(s) from the protocols on use of force

- that management ensure focus on precise and comprehensive documentation in records about forced immobilisation, including stating precise and comprehensive grounds for maintaining belt restraint, which – in connection with restraint for longer than a few hours – observe the more rigorous requirements set out in Section 14(3) of the Mental Health Act

- that management ensure new medical assessment of the need for continued forced immobilisation in accordance with the applicable rules

- that management ensure that house rules and practice are in accordance with applicable law

- that management ensure that no interventions are carried out without the patients' consent with respect to shielding in own room

- that management ensure that consent to shielding in own room is documented in accordance with the relevant applicable rules and practice

Mental Health Services in Region Zealand, Slagelse Psychiatric Hospital
One integrated psychiatric ward for adults and psychiatric emergency admission
12 October
Talks with 6 users and 5 relatives
DIGNITY and IMR participated

Recommendations

- that management ensure continued focus on preventing and reducing use of force, including focus on preventing that belt restraint is maintained for longer than a few hours

- that management ensure continued focus on follow-up interviews being offered and documented in accordance with the applicable rules, including documenting offered follow-up interviews and the reason that offered follow-up interviews are not carried out

- that management ensure that the 2017 guideline on forced immobilisation is kept up-to-date

- that management ensure documentation that the patients have been informed about the access to complain about force used

- that management ensure that the name(s) of the involved staff appear(s) from the protocols on use of force

- that management ensure focus on precise and comprehensive documentation in records about forced immobilisation, including stating precise and comprehensive grounds for maintaining belt restraint, which – in connection with restraint for longer than a few hours – observe the more rigorous requirements set out in Section 14(3) of the Mental Health Act

- that management ensure that house rules and practice are reviewed and adjusted in accordance with the Ministry of Health's statements most recently forwarded from Danish Regions to the regions on 26 March 2021, so that no extensive measures are carried out without the patients' consent or clear legal authority with respect to restriction of sexual intercourse

- that management ensure that no interventions are carried out without the patients' consent with respect to shielding in own room

- that management ensure that consent to shielding in own room and other extensive measures is obtained and documented in accordance with the relevant applicable rules and practice

Prison and Probation Service institutions in Greenland
7-20 October
'Anstalten for Domfældte', Tasiilaq
'Anstalten for Domfældte', Sisimiut
'Anstalten for Domfældte', Aasiaat
'Anstalten for Domfældte', Qaqortoq
'Anstalten for Domfældte', Ilulissat
'Anstalten for Domfældte', Nuuk
Talks with 22 users

Recommendations to the Prison and Probation Service in Greenland

- ensuring increased attention in the institutions on whether the rules on placement in solitary confinement are applied correctly, including distinguishing between solitary confinement under Section 223 and under Section 227 of the Greenland Criminal Code

- following up on whether 'Anstalten for Domfældte' in Aasiaat has ensured that inmates cannot let themselves into each other's rooms

- ensuring that the staff in the institutions are systematically instructed in how to prevent and become aware of harmful effects of isolation

- ensuring that the institutions have increased attention on documentation of the basis for placement in observation and solitary confinement cells and the need for maintenance of the placements

- reviewing the house rules in order to ensure that they are in accordance with the applicable rules, and ensuring that the house rules state that criminal offences can lead to a report to the police, and that it is possible for detainees to complain to the district court

- ensuring that the house rules are made easily available to the inmates

- drafting guidelines for handling violence and threats among inmates

- implementing a fixed procedure for screening whether inmates are at risk of suicide
- ensuring that trained staff are always present in the institutions

- ensuring that the institutions follow the Prison and Probation Service's guidelines on instructions in the event of fire

Recommendations to individual institutions
'Anstalten for Domfældte' in Tasiilaq:
- ensuring that meetings with the inmates are held regularly

'Anstalten for Domfældte' in Sisimiut:
- making it clear what terms apply to convicted persons staying in the institution

'Anstalten for Domfældte' in Aasiaat:
- ensuring as soon as possible that inmates cannot let themselves into each other's rooms

- ensuring that voluntary placement in solitary confinement in the institution is monitored, including in relation to focus on possible harmful effects of isolation

- ensuring that there is an overview of complaints about and suspicion of harassment, bullying, violence and threats etc. among the inmates

'Anstalten for Domfældte' in Qaqortoq:
- ensuring that complaints from inmates are answered

'Anstalten for Domfældte' in Ilulissat:
- ensuring that minutes are taken of meetings with the inmates and meetings with the inmate spokespersons

'Anstalten for Domfældte' in Nuuk:
- ensuring increased attention on the hierarchies among the inmates and considering initiatives to prevent and reduce harassment and bullying among the inmates

- ensuring that the minutes of the meetings with the inmates are worded neutrally

Police authorities in Greenland
7-19 October
Police station, Kangerlussuaq (with detention facility)
Municipal bailiff, Sarfannguit (without detention facility)
Municipal bailiff, Kulusuk (with detention facility)
Police station, Tasiilaq (with detention facility)
Police station, Aasiaat (with detention facility)
Municipal bailiff, Narsarsuaq (with detention facility)
Municipal bailiff, Saarloq (without detention facility)
Municipal bailiff, Alluitsup Paa (with detention facility)
Municipal bailiff, Kangaatsiaq (with detention facility)
Police station, Qaqortoq (with detention facility)
Municipal bailiff, Oqaatsut (without detention facility)

Police station, Ilulissat (with detention facility)
Police station, Nuuk (with detention facility)
Municipal bailiff, Kapisillit (without detention facility)
Talk with 1 user

Recommendations to the Chief Constable of Greenland

- ensuring that guidelines on fire safety are followed, including in relation to
    - alarm call to the fire service when fire detectors are triggered
    - the possibility of evacuation of inmates

- increasing focus on the police's self-inspection of the physical conditions in the detention facilities, including in relation to
    - ensuring that calling systems and video surveillance are working, and especially
    - that the calling systems in the detention facilities in Kangerlussuaq and Aasiaat are fixed as soon as possible

- ensuring that all municipal bailiffs and police stations have the equipment to relieve the effects of pepper spray
- considering if there is a need to draft instructions for medicines management and the documentation thereof

- considering if there is a need for rules about more intensive monitoring of detainees needing medical attention who are placed in the detention facility before they are seen by a doctor
- ensuring that police stations and municipal bailiffs have the necessary information leaflets about the detainees' rights, including in relation to use of force with, for instance, pepper spray
- ensuring that the information about rules – or references thereto – in the detention facilities are kept up-to-date
- updating the orders of the day about detention facilities and municipal bailiffs, so that it is clear
    - how often detainees must be monitored in detention facilities without permanent police staffing
    - how placement in detention facilities must be documented
    - when the custodial parent or guardian must be informed about placement of a minor in a detention facility

- ensuring that detainees' stay in the detention facilities takes place in accordance with the special rules applicable to this group, including in relation to access to open air and the furnishing of the cells

- increasing the focus on teaching staff who have not been trained in Greenland about the Greenlandic rules on detention facility placement
- ensuring that the municipal bailiffs receive peer-to-peer training and participate in a training course for municipal bailiffs
- increasing the focus on ensuring correct and comprehensive documentation, for instance in relation to
    - monitoring of the detainees
    - searching, including which officers participated in the search
    - notifying custodial parents or guardians and the social authorities in cases about minors
    - account to a doctor, including the background for a detainee having been placed in the detention facility before receiving medical attention
    - detained and convicted persons' access to open air and the furnishing of their cells

Recommendation to individual police authorities
The municipal bailiff in Kapisillit:

- to seek to enter an agreement with, for instance, the municipality about using a suitable room for deprivations of liberty, if any

Overview: Monitoring visits to institutions etc. for children in 2021

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 people (referred to below as ‘users’) and with relatives and, if rele-vant, guardians (referred to below as ‘relatives etc.’). The Ombudsman collaborates with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights (IMR) on monitoring activities. Among other things, they participate in a number of monitoring visits. It is stated for each visit whether DIGNITY and/or IMR participated. Finally, the rec-ommendations made in connection with the individual visit are presented.

MONITORING VISITS	NO. OF VISITS
NO. OF VISITS	9
TALKS WITH USERS	68
TALKS WITH RELATIVES ETC.	76
WITH DIGNITY	9
WITH IMR	4
ANNOUNCED/ UNANNOUNCED VISITS	8/1
PHYSICAL/ VIRTUAL VISITS	3/6
CONCLUDED WITH RECOMMENDATIONS	9
CONCLUDED WITHOUT RECOMMENDATIONS	0

Monitoring Visits

'Stevnsfortet', Rødvig Stevns
20 and 21 January
Secure residential institution
In-house school
Talks with 7 users and 6 relatives
DIGNITY participated in the visit

Recommendations
The visiting team recommended that 'Stevnsfortet':

- ensure that its internal guidelines on use of physical force, seclusion and drug testing describe the central requirements under the applicable rules, including in relation to the powers of staff

- observe the deadlines for recording and reporting use of physical force, episodes of seclusion and body searching and searches of living spaces

- ensure that the holders of parental responsibility are informed following use of physical force and following body searching and searches of living spaces, and that this is stated in the report forms

- ensure that it is the principal or the deputy principal who makes any decision to place a child or young person in seclusion and that in the principal's absence it is clear to staff who has been designated as deputy

- update its internal guidelines on body searching and searches of living spaces in accordance with the applicable rules

- use the correct form in the Executive Order on Adult Responsibility for recording and reporting body searching and searches of living spaces

- ensure that general consent is obtained, to the relevant extent, from the children and young people placed in the institution to the use of drug testing, either when they are placed in the institution or in the course of their placement if a need for testing arises

- ensure that the placing municipality is informed when a drug test has been carried out on a child or young person, and of the result of the test

- in collaboration with the municipality of location, update the agreement on schooling in accordance with the applicable rules

- ensure compliance with the rules on teaching the full range of subjects and number of class hours

- ensure compliance with the rules on exemption from subjects and from compulsory national tests and lower secondary school examinations and ensure documentation of compliance with the rules

- ensure that the in-house school staff know the rules of the Act on Adult Responsibility that apply to use of force in the school

- ensure that children and young people who have not already undergone a psychiatric examination when placed at Stevnsfortet are offered screening to establish whether there is a need for a psychiatric examination

- consider discussing the possibility of entering into a cooperation agreement with child and adolescent psychiatric wards on, among other things, admissions and discharges

Own-initiative case opened against the Ministry of Social Affairs and Senior Citizens on connection between the rules on locking rooms at night and door alarms

'Bakkegården', Nykøbing Sjælland
10 and 11 February
Secure residential institution
In-house school
Talks with 7 users and 8 relatives
DIGNITY participated in the visit

Recommendations
The visiting team recommended that 'Bakkegården':

- ensure that its internal guidelines on use of force, seclusion, body searching and searches of living spaces and drug testing describe the central requirements under the applicable rules

- ensure that the in-house school staff know the rules of the Act on Adult Responsibility that apply to use of force in the school

- ensure that when the children and young people arrive, holders of parental responsibility, guardians and personal representatives are

informed about their rights in relation to use of force and other restrictions of the right of self-determination, including their right to complain to the National Social Appeals Board and the municipal council, respectively

- observe the deadlines for recording and reporting use of physical force and body searching and searches of living spaces

- ensure that reports on use of physical force include an adequate description of the episode and adequate information about the grounds for the use of force

- use the correct form in the Executive Order on Adult Responsibility for recording and reporting body searching and searches of living spaces

- ensure that the holders of parental responsibility are informed following body searching and searches of living spaces, and that this is stated in the report forms

- in collaboration with the municipality of location, update the agreement on schooling in accordance with the applicable rules

- ensure compliance with the rules on teaching the full range of subjects and number of class hours

- ensure compliance with the rules on exemption from subjects

- ensure compliance with the rules on exemption from compulsory tests and lower secondary school examinations

- ensure that young people who have not already undergone a psychiatric examination when placed at 'Bakkegården' are offered screening to establish whether there is a need for a psychiatric examination

- update the local and regional medicines management and other healthcare directions with, among other things, the date and details of the target group, so that they are in accordance with the guidance notes issued by the Danish Health Authority on the drawing up of directions

- consider drawing up written guidelines on detection and treatment of drug abuse etc., including withdrawal symptoms

- consider drawing up written guidelines on prevention and handling of self-harm, suicide attempts and suicides

'Kompasset', Brønderslev
3 and 4 March
Secure residential institution
In-house school
Talks with 6 users and 7 relatives
DIGNITY and IMR participated in the visit

Recommendations
The visiting team recommended that 'Kompasset':

- ensure that when the children and young people arrive, parents, guardians and personal representatives are informed about their rights in relation to use of force (and other restrictions of the right of self-determination)

- expand its guidelines on seclusion to state (a) that a child or young person in seclusion must be able to summon staff for the duration of the seclusion, and (b) that a doctor of psychiatry (or a general practitioner) must be summoned if a child or young person who is placed in seclusion has a mental disorder

- ensure documentation that the deadlines for recording and reporting episodes of seclusion have been observed

- update its guidelines on body searching and searches of living spaces to describe the central requirements under the applicable rules

- ensure compliance with the rules on teaching the full range of subjects and number of class hours

- ensure compliance with the rules on exemption from subjects and from compulsory national tests and lower secondary school examinations and ensure documentation of compliance with the rules

'Grenen-Dalstrup', Grenaa
13 and 14 April
Secure residential institution with special secure ward
In-house school
Talks with 8 users and 9 relatives
DIGNITY and IMR participated in the visit

Recommendations
The visiting team recommended that 'Grenen-Dalstrup':

- observe the deadlines for recording and reporting use of physical force, episodes of seclusion and body searching and searches of living spaces

- ensure that it is the principal or the deputy principal who makes any decision to place a child or young person in seclusion, and that in the principal's absence it is clear to staff who has been designated as deputy

- consider drawing up internal guidelines on body searching and searches of living spaces
- complete updating, in collaboration with the municipality of location, the agreement on schooling in accordance with the applicable rules

- ensure compliance with the rules on teaching the full range of subjects to the extent that the in-house school is not subject to rules on emergency schooling which entitle the school to deviate from the former rules

- ensure that decisions to exempt a pupil from a subject are based on a pedagogical-psychological assessment

- ensure compliance with the rules on exemption from compulsory tests and lower secondary school examinations

- ensure that children and young people who have not already undergone a psychiatric examination when placed at 'Grenen-Dalstrup' are offered screening to establish whether there is a need for a psychiatric examination

- increase focus on identifying young people who have or are at risk of developing withdrawal symptoms when placed in the institution, for instance by carrying out drug tests, and ensure treatment for withdrawal symptoms

Own-initiative case opened against Norddjurs Municipality regarding reduction in the number of class hours

'Koglen', Stakroge
5 and 6 May
Secure residential institution
In-house school
Talks with 3 users and 5 relatives

DIGNITY participated in the visit

Recommendations
The visiting team recommended that 'Koglen':

- observe the deadlines for recording and reporting use of physical force, episodes of seclusion and body searching and searches of living spaces

- consider drawing up internal guidelines on body searching and searches of living spaces

- complete updating, in collaboration with the municipality of location, the agreement on schooling in accordance with the applicable rules

- ensure compliance with the rules on teaching the full range of subjects to the extent the in-house school is not subject to rules on emergency schooling which entitle the school to deviate from the former rules

- ensure compliance with the rules on exemption from subjects

- ensure compliance with the rules on exemption from compulsory tests and lower secondary school examinations

- increase focus on identifying young people who have or are at risk of developing withdrawal symptoms when placed in the institution, for instance by carrying out drug tests, and ensure treatment for withdrawal symptoms

- consider discussing the possibility of entering into a cooperation agreement with child and adolescent psychiatric wards on, among other things, admissions and discharges

- ensure that children and young people who have not already undergone a psychiatric examination when placed at 'Koglen' are offered screening to establish whether there is a need for a psychiatric examination

'Sølager', Hundested and Skibby
26 and 27 May
Secure residential institution
In-house school
Talks with 2 users and 10 relatives
DIGNIY participated in the visit

Recommendations
The visiting team recommended that 'Sølager':

- continue the process of drawing up written guidelines on use of physical for
- observe the deadlines for recording and reporting use of physical force and body searching and searches of living spaces
- ensure that reports on use of physical force include an adequate description of the episode and adequate information about the grounds for the use of force
- ensure that reports on personal and room searches include an adequate description of the measure
- ensure that when the children and young people arrive, the children, young people, holders of parental responsibility, guardians and personal representatives are informed about their rights in relation to use of force and other restrictions of the right of self-determination, including their right to complain to the National Social Appeals Board and the municipal council, respectively
- ensure that following body searching and/or searches of living spaces the children and young people are informed that the search has been recorded and are given the opportunity to comment on the episode
- in collaboration with the municipality of location, update the agreements on schooling in accordance with the applicable rules
- ensure compliance with the rules on teaching the full range of subjects and number of class hours
- ensure compliance with the rules on exemption from compulsory tests and lower secondary school examinations
- draw up written guidelines on how sexual abuse is to be prevented and the procedure for handling suspected abuse
- consider the possibility of again entering into an agreement with a local general practitioner on assistance with medical care for residents during their placement at 'Sølager'

- ensure continued focus on identifying young people who have or are at risk of developing withdrawal symptoms when placed in the institution and ensure treatment for any withdrawal symptoms

'Socialcenter Lillebælt – Egely', Nørre-Aaby
8 and 9 September
Secure residential institution with special secure ward
In-house school
Talks with 11 users and 9 relatives
DIGNITY and IMR participated in the visit

Recommendations
The visiting team recommended that 'Socialcenter Lillebælt – Egely':

- observe the deadlines for recording and reporting use of physical force, seclusion and body searching and searches of living spaces

- ensure that reports on use of physical force, seclusion and body searching and searches of living spaces include an adequate description of the episode and adequate information about the grounds for the use of force

- in collaboration with the region ensure that guidelines on use of force comply with applicable rules

- ensure that the written information to the children and young people on the Act on Adult Responsibility and their rights in relation to, among other things, use of force and other restrictions of the right to self-determination includes an adequate description of the applicable rules

- expand its guidelines on seclusion to state (a) that a child or young person in seclusion must be able to summon staff for the duration of the seclusion, and (b) that a doctor of psychiatry (or a general practitioner) must be summoned if a child or young person who is placed in seclusion has a mental disorder

- ensure that it is the principal or the deputy principal who makes any decision to place a child or young person in seclusion, and that in the principal's absence it is clear to staff who has been designated as deputy

- cease video monitoring children and young people who have been placed in seclusion

- in collaboration with the municipality of location, update the agreement on schooling in accordance with the applicable rules

- ensure compliance with the rules on teaching the full range of subjects and number of class hours

- ensure compliance with the rules on exemption from subjects and from compulsory national tests and lower secondary school examinations and ensure documentation of compliance with the rules

- ensure that children and young people who have not already undergone a psychiatric examination when placed at the institution are offered screening to establish whether there is a need for a psychiatric examination

- consider how it is to a wider extent possible to ensure that children and young people can have general dental examinations regularly

- consider – possibly with the involvement of the region – whether an agreement can again be established with a general practitioner in the local community who can assist with the treatment of the children and young people for the duration of their placement at Egely

- update healthcare directions so as to bring them into line with applicable practice and relevant legislation, including directions for psychological screening and directions on medicines management

Own-initiative case opened against the Ministry of Social Affairs and Senior Citizens on connection between the rules on locking rooms at night and door alarms

'Sønderbro', Copenhagen
13 and 14 October
Secure residential institution with special secure ward
In-house school
Talks with 11 users and 11 relatives
DIGNITY participated in the visit

Recommendations
The visiting team recommended that 'Sønderbro':

- ensure that staff are familiar with Section 9(3) of the Act on Adult Responsibility on use of physical force when mandatory house rules have been breached

- ensure that the written information to the children and young people on the Act on Adult Responsibility and their rights in relation to, among other things, use of force and other restrictions of the right to self-determination includes an adequate description of the applicable rules

- observe the deadlines for recording and reporting use of physical force and body searching and searches of living spaces

- record and report use of physical force in a form which in terms of contents correspond to the form in the Executive Order on Adult Responsibility

- consider drawing up internal guidelines on body searching and searches of living spaces

- use the correct form in the Executive Order on Adult Responsibility for recording and reporting body searching and searches of living spaces

- check that the institution has authority to use video monitoring on outside areas

- cease practice of searching visitors by means of a scanner

- in collaboration with the City of Copenhagen, ensure that the in-house school is approved in accordance with applicable rules

- ensure compliance with the rules on teaching the full range of subjects and number of class hours

- ensure that the use of individual teaching complies with applicable rules

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

'Fårupgård', Jelling
9 and 10 November
Open residential institution
In-house school
Talks with 13 users and 11 relatives
DIGNITY and IMR participated in the visit

Recommendations

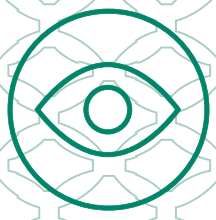
The visiting team recommended that 'Fårupgård':

- update guidelines on use of force so that they comply with the rules of adult reponsibility legislation regarding deadlines for recording and reporting use of force

- observe the deadlines for recording and reporting use of physical force and body searching and searches of living spaces

- ensure compliance with the rules on general consent to drug testing and voluntary participation in specific tests, including that all staff are familiar with the new guidelines, and that the children and the young people are informed of their rights in this regard

- ensure that all staff are familiar and comply with the new house rules, and that the children and the young people are informed of the house rules



Part Three

Thematic reports 2021

Thematic report 2021: Force and non-statutory interventions in the psychiatric sector

Contents

1. Introduction

During 10 monitoring visits to psychiatric wards in 2021, the Ombudsman investigated the use of various kinds of measures towards psychiatric patients. The investigation dealt with both forcible measures under the Mental Health Act and non-statutory measures.

Admission, stay and treatment in a psychiatric ward are generally voluntary, meaning based on informed consent from the patient.

However, forced admission to a psychiatric ward and forced treatment can take place under certain conditions under the rules in the Mental Health Act, which also allows for the use of particular forcible measures during admission such as manual restraint of the patient and belt restraints.

During the investigation of force under the Mental Health Act, the Ombudsman focused on whether the conditions for using force were observed and whether this was documented sufficiently. In addition, the Ombudsman investigated whether there was focus on preventing and reducing use of force.

In practice, patients in psychiatric wards can also be subjected to measures that are not regulated by the Mental Health Act. In some instances, such non-statutory measures appear in the ward's house rules. The Ombudsman's investigation focused on whether non-statutory measures in house rules or otherwise used in practice had the sufficient legal basis, including whether the measures constituted interventions that required valid consent from the patients.

2. General recommendations and follow-up

2.1. Force under the Mental Health Act

The psychiatric wards generally focused on preventing and reducing use of force, for instance through the initiatives that the Danish Health Authority recommend using in this connection.

However, several of the wards had not yet succeeded in implementing the relevant initiatives or in reducing use of force.

The Ombudsman generally recommends that the regions ensure continued focus on preventing and reducing use of force in the psychiatric sector.

The psychiatric wards generally focused on ensuring that the rules on force are observed. However, the Ombudsman gave recommendations to some wards that aimed to ensure that the rules on use of force are observed in practice. The recommendations especially concerned

- change of internal guidelines so they correspond to the rules on when forced immobilisation must stop and instructions to staff in this regard
- observation of time-related requirements to the medical evaluations of whether forced immobilisation is to be maintained
- ensuring that manual restraints do not last more than 30 minutes.

The Ombudsman generally recommends that the regions ensure focus on observing the rules on force.

As part of the monitoring visits, the Ombudsman's visiting teams reviewed some examples of records on forced immobilisation that did not contain sufficient documentation of compliance with the rules. Especially in regard to documentation that the conditions were met for maintaining forced immobilisation for more than a few hours.

Based on discussions with management in the psychiatric wards in question, the visiting teams did not find that the conditions had not been met for carrying out the specific forced immobilisations. Instead, the visiting teams pointed to a need to improve the documentation.

The Ombudsman generally recommends that the regions ensure focus on precise and comprehensive documentation in records on forced immobilisation – including in relation to the grounds for initiating and maintaining belt restraints – which observes the more rigorous requirements of Section 14(3) of the Mental Health Act in cases of restraint lasting more than a few hours.

Based on information from several of the psychiatric wards, the Ombudsman has also opened an own-initiative investigation of the Ministry of Health about the legal framework for private guards' use of force in psychiatric wards.

2.2. Non-statutory measures and interventions

The Ombudsman's visiting teams saw a number of examples of practices and rules in the wards' house rules that did not have authority in the Mental Health Act and where there was doubt whether the practices or rules could be maintained without statutory authority.

Prior to the thematic investigation, some of the examples had been dealt with in the Ombudsman's cases on non-statutory measures and interventions and

were discussed during meetings with the relevant ministry and Danish Regions. The cases are described in item 6.1.1 below.

Other examples, such as rules that the patients could not talk to each other about certain topics, had not been dealt with in the Ombudsman's cases or during meetings with the relevant ministry and Danish Regions prior to the thematic investigation. During a meeting in 2021 with the Ministry of Health, the Ombudsman spoke about these examples.

Since 1 January 2022, new rules in the Mental Health Act have made it possible to use some of the observed measures and interventions without obtaining the patient's consent in advance.

The Ombudsman generally recommends that the regions ensure that house rules and practices in the wards observe the applicable rules.

Some of the examples of rules and practices that the Ombudsman's visiting teams observed in the wards are not mentioned (expressly) in connection with the above-mentioned amendment of the Mental Health Act or in the related executive order. For instance, the patients could have their access to unhealthy food and drinks restricted. There were also examples where patients had restricted access to receiving visitors from the outside – such as relatives – or where the visits were being monitored. The Ombudsman will discuss the legal framework of these examples with the Ministry of Health.

In addition, the Ombudsman's visiting teams found that the intervention 'seclusion in own room' is used in several wards (for instance referred to as 'environmental seclusion', 'area restriction' or 'reflection time'). The intervention is generally characterised by a patient being isolated in his or her own room or another limited area with an unlocked door and possibly with members of staff standing guard outside the door. At the time of the monitoring visits, it had been clarified in the Ombudsman's Case No. FOB 2020-25 (in Danish at the Ombudsman's website) that such interventions could only be used with the patient's consent. Read more about this in item 6.1.

During six monitoring visits, the Ombudsman recommended that management ensure that no seclusion in own room (or other area restriction) takes place without the patient's consent.

The Ombudsman has subsequently opened an own-initiative investigation of a forensic psychiatric ward and the Ministry of Health about whether – after the above-mentioned amendment of the Mental Health Act on 1 January 2022 – there is authority to carry out seclusion in own room without the patient's consent.

In connection with consent to a non-statutory intervention, there are requirements for how consent is obtained and documented. For instance, the patients must be informed that they can at any time withdraw their consent, and staff must assess whether the patients are able to give consent. In a number of instances, the consent requirements were not met. This was the case both in relation to seclusion in own room and other interventions. During nine monitoring visits, the Ombudsman recommended that management ensure that consent to seclusion in own room and other interventions is obtained and documented in accordance with the relevant requirements set out in applicable rules and practices.

The Ombudsman generally recommends that the regions ensure that no non-statutory interventions are carried out without consent that has been obtained and documented in accordance with the relevant requirements set out in applicable rules and practices.

2.3. Follow-up

The Ombudsman's general recommendations in this thematic report are directed at the regions, including the psychiatric wards, which have the principal responsibility for the daily administration and handling of tasks in relation to the stated issues in the psychiatric sector.

However, the general recommendations are also directed at the Ministry of Health, which has the overall responsibility in the field.

The Ombudsman will discuss the follow-up of the general recommendations with the Ministry of Health and Danish Regions. The Ombudsman will also follow up on the general recommendations during future monitoring visits.

3. Basis for the choice of the investigation's theme

With the theme for 2021, the Ombudsman wanted to gain up-to-date knowledge of the conditions for patients admitted in the psychiatric sector with focus on use of force. The Ombudsman also wanted to follow up on the fact that monitoring visits during a period of time had revealed that various kinds of non-statutory measures and interventions appeared in house rules or were otherwise used in practice in psychiatric wards.

Force in the psychiatric sector constitutes a restriction in the patient's liberty and presupposes that it is necessary and proportional in the specific instance. Unnecessary force can constitute a violation of Article 3 of the European Convention on Human Rights on inhuman and degrading treatment.

As the result of an agreement in 2014 between the (then) Ministry of Health and Prevention and Danish Regions, each region entered into a partnership agreement with the Ministry, which led to common objectives that the number of patients subjected to forced immobilisation was to be halved in 2020 and that there was also to be a reduction in the overall use of force.

The Danish Health Authority's monitoring of force in the psychiatric sector in 2020 showed that the regions had generally succeeded in considerably reducing the number of persons who were subjected to belt restraints. However, the use of force had generally increased in the period since the agreement in 2014.

In addition, Denmark has been criticised by the European Committee for the Prevention of Torture (CPT) for the use of belt restraints, including especially long-term belt restraints, most recently in connection with a visit in 2019. In the autumn of 2020, the European Court of Human Rights delivered a judgment in a case against Denmark, where the Court found that a specific belt restraint episode in a psychiatric ward constituted a violation of Article 3 of the European Convention on Human Rights.

Furthermore, during a follow-up period regarding several monitoring visits to psychiatric wards, the Ombudsman had processed a number of cases about use of various non-statutory measures and interventions. The use thereof had been discussed during meetings with the relevant ministry – now the Ministry of Health – and Danish Regions.

4. Investigation method

4.1. How was the investigation organised?

The theme was investigated during 10 monitoring visits to psychiatric wards, where some of the visits included several units. The visits covered both units within the general and the forensic psychiatric sector, including the Maximum Security Unit (in Danish: 'Sikringsafdelingen') at the Department of Forensic Psychiatry, Region Zealand, where special rules apply.

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. The Institute for Human Rights contributes with special human rights expertise. DIGNITY contributes to the cooperation with medical expertise. Among other things, this means that staff with expertise in these two fields from the two institutes participate in the planning and execution of and follow-up on monitoring visits.

4.2. How were conditions investigated during the monitoring visits?

In the opening letter for the individual monitoring visit, management in the visited psychiatric ward was asked for information on a number of factors and for copies of the material on the subject.

This concerned, among other things, statistical information about the use of various kinds of force, guidelines for use of force as well as protocols on force and records about a number of instances of forced immobilisation. In addition, the Ombudsman received the units' house rules and other information on the use of non-statutory measures and interventions as well as examples of documentation of a patient's consent to non-statutory interventions.

During the monitoring visits, management, staff, patients, patient advisers and guardian representatives, guardians and relatives were interviewed about conditions for the patients, including in particular the conditions that were in focus during the Ombudsman's visit in 2021.

5. Force under the Mental Health Act

5.1. Is there focus on preventing and reducing use of force?

5.1.1. Starting point of the investigation

The Ombudsman's visiting teams investigated whether there was focus on preventing and reducing use of force at the visited units.

The investigation used as its starting point the report 'Recommendations for reducing use of force towards people with mental disorders' (in Danish: 'Anbefalinger for nedbringelse af tvang for mennesker med psykiske lidelser'), published by the Danish Health Authority in January 2021.

In the report, the Danish Health Authority recommends, among other things, that the work with preventing or reducing use of force in the psychiatric sector be based on six so-called core strategies.

The six core strategies:

1. Management aimed at organisational changes
2. Use of data for information-based practice
3. Development of the staff's skills and professional knowledge
4. Use of force prevention tools
5. The patient's role in psychiatric wards
6. Use of debriefing techniques

The Danish Health Authority also recommends that compulsory admissions be prevented. This presupposes cooperation with actors outside the psychiatric wards.

Furthermore, the Mental Health Act contains rules on various initiatives in relation to the individual patient in order to prevent force, among other things. The visiting teams investigated whether these initiatives are used in practice.

Examples of initiatives in the Mental Health Act with the purpose of preventing force:

1. Advance statements
The patient must be asked about any statements of preferences in relation to treatment, including if use of force should become relevant.

2. Follow-up interviews
During a follow-up interview, the patient and staff go through their experience of the force used. The purpose is to prevent and reduce use of force towards the patient.

3. Discharge agreements and coordination plans
Agreements or plans must be made for certain patients who receive support under the Social Services Act. Actors that are relevant after discharge must be involved – for instance the patient, the psychiatric sector, the municipality and any support from social services. The agreements and plans must support a good transition to daily life after hospitalisation.

The visiting teams investigated the statistical development in the use of force in the visited psychiatric wards.

According to the Danish Health Authority, the national focus on halving the number of belt restraint episodes may lead to other forcible measures being used instead. The visiting teams looked at whether the development in the visited ward could indicate a substitution between forcible measures, for instance that belt restraints were replaced by long-term manual restraints or increased use of acute sedatives administered with force.

5.1.2. Result of the investigation

The Ombudsman's visiting teams found that the psychiatric wards generally focused on preventing and reducing use of force. The visited units had typically implemented, or were in the process of implementing, a number of the initiatives that the Danish Health Authority recommends using in the work with preventing and reducing use of force. However, several units had not yet succeeded in implementing the relevant initiatives or reducing use of force.

Generally, the wards pointed out that it required a cultural change, which took time to complete. Several of the psychiatric wards pointed to a lack of (permanent) staff and the patients' problems with drug abuse as some of the main causes of situations where force was necessary. The wards also pointed out that it is more often necessary to use force towards patients with externalising or boundary-crossing behaviour. In addition, the significance of the physical setting to the prevention of force was pointed out.

The Ombudsman recommended to six wards that management ensure continued focus on preventing and reducing use of force. In addition, it was recommended that one ward ensure that valid and current figures for the use of force are available continuously and consider if there are grounds for setting specific objectives for reducing use of force.

At some wards, either the use of manual restraint, compulsory administration of sedatives or both had increased while the use of forced immobilisation had decreased.

Based on the obtained information and discussions with the relevant psychiatric wards, the visiting teams could not conclude that there had been a substitution of forced immobilisations with manual restraints (lasting more than 30 minutes) or compulsory administration of sedatives. Instead, these matters formed part of the basis for the recommendations to ensure continued focus on preventing and reducing use of force.

The Ombudsman did not recommend that management ensure the obtainment of advance statements or the drawing-up of discharge agreements and coordination plans. The mentioned initiatives are described in item 5.1.1. Some of the psychiatric wards stated that it could be difficult to

draw up advance statements immediately after admission, where the patients are usually feeling at their worst.

The Ombudsman gave a total of six recommendations about follow-up interviews; in two of them, it was recommended that management ensure that the patients are offered follow-up interviews. The other four recommendations concerned documentation of the follow-up interviews, among other things because it can be difficult to follow up on a held interview if there is no documentation of the contents of the interview.

5.2. Is there focus on ensuring compliance with the rules on force?

5.2.1. Starting point of the investigation

The Ombudsman's visiting teams investigated whether the psychiatric wards focused on ensuring that the rules on force are observed.

The Mental Health Act contains a number of rules that apply in all instances of force. For instance, force cannot be used until all possible alternatives have been tried in order to achieve the patient's voluntary cooperation. If less restrictive measures are sufficient, these must be used instead.

Also, according to the general rules, the patient's advance statement (see item 5.1.1) must be included in the assessment of what is least restrictive for the patient in a specific situation. For instance, according to the Ministry of Health, it cannot be argued generally that manual restraints are less restrictive than forced immobilisations.

In addition to the general rules, there are special conditions for the individual type of intervention. For example, forced immobilisations can as a rule only be used briefly and to the extent necessary in order to, for instance, prevent the patients from putting themselves or others at immediate risk of harm to body or health.

Furthermore, there are rules on re-evaluating whether or not to maintain long-term forcible measures. For example, forced immobilisations must as a rule be re-evaluated three times in every 24 hours. In addition, there are rules on external evaluations of the maintaining of forced immobilisations.

The purpose of several rules in the Mental Health Act is to ensure the patients' subsequent legal rights after use of force. Among other things, it is possible to complain, and a patient must be assigned a patient adviser to guide and advise the patient and to assist with submitting a complaint and carrying through the complaint process.

As part of the investigation, the visiting teams reviewed local guidelines on force and spoke with the psychiatric wards about how they follow up on cases where a patient complains about the use of force and where the ward's decision to use force is not upheld. The psychiatric wards also explained how it is ensured that staff are familiar with the rules. Lastly, information about records on forced immobilisations was included in this part of the investigation.

5.2.2. Result of the investigation

The visiting teams found that the psychiatric wards generally focused on ensuring compliance with the rules on force. Many wards focused on (supplementary) training and supervision of staff, updating internal guidelines and analysing the Psychiatric Patients' Board of Complaint's overrulings of use of force. The visiting teams also found that the patients were generally given information about use of force, assigned patient advisers and guided about the option to complain.

However, recommendations were also given in order to ensure that the rules on use of force are observed in practice. This is due to three matters in particular.

Firstly, several wards had local guidelines or action cards on when forced immobilisation should stop, which did not comply with the applicable rules. In addition, staff in some wards were unaware that care staff can stop forced immobilisation when it is no longer necessary to maintain it.

In four instances, it was recommended that management ensure that the local guidelines or action cards about force are updated so that they are in accordance with the applicable rules. In two instances, the Ombudsman recommended that management ensure that staff are instructed in the care staff's access to stop forced immobilisation. In one instance, the Ombudsman recommended that management ensure that it is determined as soon as possible whether a patient's restraints can be loosened when an external doctor has assessed that there are no longer grounds for immobilising the patient.

Secondly, a long time could pass between the medical evaluations of whether or not to maintain belt restraints (belt inspections). The visiting teams saw many examples where 11 to 17 hours would pass between these re-evaluations. According to the rules applying at the time, the doctor should carry out three belt inspections that should be distributed equally over the course of 24 hours.

During seven monitoring visits, the Ombudsman recommended that management ensure that new medical evaluations of the question of

continued forced immobilisation are carried out in accordance with the applicable rules. In one instance, it was recommended that management ensure that external medical inspections are carried out in connection with long-term immobilisations.

After a legislative amendment on 1 January 2022, the Mental Health Act now states how much time is generally allowed to pass between two belt inspections.

Thirdly, management in the psychiatric wards and the visiting teams discussed compliance with the applicable guidelines about the use of manual restraints. One ward stated that they do not use manual restraints at all unless the patients specifically requested this in, for instance, their advance statement. A different ward generally viewed manual restraints as less restrictive than forced immobilisations. Some wards used manual restraints for more than 30 minutes.

In three instances, it was recommended that management ensure that long-term manual restraints lasting more than 30 minutes are avoided, and in one instance, it was recommended that management ensure that short-term manual restraints only take place after a specific assessment, which takes into account the patient's advance statement.

The Ombudsman also gave a few recommendations to ensure documentation of complaint guidance or to ensure systematic follow-up of overrulings by the Psychiatric Patients' Board of Complaint and to make staff aware of the practice.

In addition, during several monitoring visits, the visiting teams were informed that the wards used private guards. The guards would typically intervene if the patients exposed staff to violence. In some cases, the guards could use physical force towards the patients. The Ombudsman did not give recommendations to the visited psychiatric wards but has opened an own-initiative investigation of the Ministry of Health about the legal framework for private guards' use of force in psychiatric wards.

5.3. Is there documentation for compliance with the rules on force?

5.3.1. Starting point of the investigation

The Ombudsman's visiting teams investigated whether there was documentation for compliance with the rules on force.

As part of the investigation, the visiting teams reviewed two to four protocols on force from each psychiatric ward concerning forced immobilisation with belt and possibly straps and gloves along with relevant records. The material

was compared with the rules in the Mental Health Act and related executive orders and guidelines as well as practices from the courts and the Psychiatric Patients' Board of Complaint.

What is the purpose of documenting forcible measures?

Documentation of forcible measures such as forced immobilisation serves several purposes. The documentation can thus form the basis of analyses and follow-up of specific episodes with force and thereby be part of the work with preventing force. In addition, documentation ensures that the patients or their representatives can get an insight into what happened. Documentation can also support compliance with rules and be included in cases with complaint bodies and the courts, which determine if a measure is justified.

See more about the duty to take notes at the Ombudsman's website (in Danish) and more about data on forcible measures and analysis of the individual forcible measures at the Danish Health Authority's recommendations for reducing force for people with mental disorders (in Danish).

In practice from the Psychiatric Patients' Board of Complaint and the courts, there are several examples that insufficient documentation of for instance the patient's dangerous behaviour has been significant when forced immobilisations are overruled.

5.3.2. Result of the investigation

The received documentation was not reviewed in order to assess whether there were grounds for criticising the individual forced immobilisation. On the contrary, the documentation was reviewed with the preventive purpose of ensuring partly that no force is carried out that does not meet the requirements of the Mental Health Act, partly that the documentation lives up to the requirements of the Act.

The visiting teams saw a number of examples of records on forced immobilisations not containing sufficient documentation that the forced immobilisations complied with the rules.

There were a few examples of insufficient documentation that the patients were at risk of harming themselves or others upon immobilisation. For

instance, one record stated that the patient 'lay down calmly' when the patient was immobilised.

Furthermore, there were examples where there were no separate grounds for using wrist or ankle straps and maintaining the use of these.

In addition, there were a number of examples of insufficient documentation for maintaining immobilisation lasting more than a few hours. According to Section 14(3) of the Mental Health Act, a patient can only be immobilised by force for longer than a few hours when so prompted by the consideration of the patient's or others' life, health or safety.

For example, a patient was described as 'prone to anger', 'verbally aggressive' and 'having many needs'. Another patient was described as 'clearly angry and verbally aggressive – turns up radio loudly and lies with the back to me and facing the loudspeaker directly. Then orders me to leave.' There were also several examples where it was taken into account whether the patient was able to make an agreement on for instance cooperating with staff when it was to be assessed whether the patient's forced immobilisation could stop, among other things. Management stated that an assessment is made of how dangerous the patient is in all cases.

Based on discussions with the relevant psychiatric wards, the visiting teams did not find that the conditions for carrying out the specific forced immobilisations had not been met. Instead, the visiting teams pointed to the need to improve documentation.

During nine monitoring visits, the Ombudsman recommended that management ensure focus on precise and comprehensive documentation in records on forced immobilisation – including in relation to the grounds for initiating and maintaining belt restraints – which observes the more rigorous requirements of Section 14(3) of the Mental Health Act in cases of restraint lasting more than a few hours.

6. Non-statutory measures and interventions

6.1. Measures and interventions in house rules and practices

6.1.1. Starting point of the investigation

During monitoring visits to psychiatric wards in 2014 and the following years, the Ombudsman was made aware that there were large differences in the contents of rules on measures and interventions towards patients in the wards' house rules. For instance, the rules could entail that the patients had restricted access to mobile phone or visits. In the Ombudsman's opinion,

there could be doubt as to the legal basis for several of the rules in the wards' house rules and practices.

In continuation of the monitoring visits, this gave the Ombudsman occasion to open several cases about non-statutory measures and interventions. The Ombudsman also discussed these issues with the relevant ministry – now the Ministry of Health – and Danish Regions.

In the Ombudsman's Case No. FOB 2020-43 (in Danish at the Ombudsman's website), it was found that some interventions did not have authority in the Mental Health Act, for instance routine searches of the patients. In addition, there was doubt as to the legal basis for other measures and interventions such as restriction of patients' access to mobile phone and visits. Therefore, the Ministry – then the Ministry of Health and Senior Citizens – would work to create a clear legal basis so that in future there would be no doubt as to the framework for implementing restrictions in house rules in the psychiatric wards. In continuation of this, the Ministry of Health informed the regions in March 2021 that they were to adjust the house rules so they no longer contained rules on measures and interventions without authority or with doubtful legal basis, and that the adjustment could not wait for a precision of the legal basis in the Mental Health Act.

In the above-mentioned Case No. FOB 2020-25 (in Danish), the Ombudsman considered so-called 'seclusion in own room' (also referred to as 'environmental seclusion', 'area restriction' or 'reflection time'). The intervention is generally characterised by a patient being isolated in his or her own room or another limited area with an unlocked door and possibly with members of staff standing guard outside the door.

The Ombudsman stated that he agreed with the Ministry of Health and Senior Citizens that requiring a patient to stay in his or her own room without the patient's consent must be considered a forcible measure without authority in the Mental Health Act. The intervention could only be implemented with the patient's consent.

In Case No. FOB 2016-32 (in Danish at the Ombudsman's website), the Ombudsman stated that there was no authority for restricting patients' access to buying unhealthy food.

In connection with the monitoring visits in 2021, the visiting teams investigated if non-statutory measures included in house rules or otherwise used in practice had a legal basis, including if the non-statutory measures comprised interventions presupposing that the patients had given valid consent to them.

6.1.2. Result of the investigation
The visiting teams saw a number of examples of measures in the wards' house rules and practices that did not have authority in the Mental Health Act. Since those measures could constitute interventions towards the patients, it was doubtful whether they could be used without statutory authority, cf. the above-mentioned Case No. FOB 2020-43 (in Danish) about interventions without authority in the Mental Health Act.

The psychiatric wards stated that the observed measures and interventions were typically used to ensure order and safety in the wards and to benefit the treatment of the individual patient. For example, patients could have restricted access to their mobile phone so that the patients did not expose themselves in a demeaning manner, damage their relationship with relatives or suffer serious financial harm.

The wards also pointed to the fact that there could be a need for routine searches of patients and visitors to the wards to ensure that the patients did not get access to drugs in the ward.

As mentioned above, in March 2021, the Ministry of Health informed the regions that house rules about certain measures and interventions without authority in the Mental Health Act or with a doubtful legal basis were to be adjusted and that the adjustment could not wait for any precision of the legal basis in the Mental Health Act. Therefore, the Ombudsman recommended that nine psychiatric wards change the house rules and practices so that they reflected the rules applicable at the time.

In addition, the visiting teams saw examples of rules and practices that were not part of the Ombudsman's previous cases on non-statutory measures and interventions and that had not been discussed with the Ministry of Health or Danish Regions. For instance, this included rules that the patients could not speak to each other about certain topics. During a meeting in 2021 with the Ministry of Health, the Ombudsman mentioned these examples. The Ombudsman's previous cases on non-statutory measures and interventions are mentioned above in item 6.1.1.

An amendment of the Mental Health Act of 1 January 2022 made it possible to implement some of the observed measures and interventions without obtaining the patient's consent in advance.

However, it is still not possible to for instance review patients' mail regularly or search patients without suspecting that there is medicine, drugs or dangerous objects in the ward. Special rules apply at the Maximum Security Unit, forensic psychiatric wards and wards for people placed in surrogate custody.

In addition, the Ombudsman's visiting teams saw examples of rules and practices that were dealt with in the above-mentioned Case No. FOB 2016-32 and FOB 2020-43 (in Danish). For instance, the patients could have their access to unhealthy food and drinks restricted. There were also examples of patients having restricted access to receiving visitors from the outside – such as relatives – or where the visits were monitored. These examples are not (expressly) referred to in the mentioned amendment to the Mental Health Act or the related executive order.

Furthermore, the visiting teams found that the intervention 'seclusion in own room' is used in several wards (for instance referred to as 'environmental seclusion', 'area restriction' or 'reflection time'). The intervention is generally characterised by a patient being isolated in his or her own room or another limited area with an unlocked door and possibly with members of staff standing guard outside the door. At the time of the monitoring visits, it had been clarified in the Ombudsman's above-mentioned Case No. FOB 2020-25 (in Danish) that such interventions could only be used with the patient's consent.

During six monitoring visits, the Ombudsman recommended that management ensure that no seclusion in own room (or other area restriction) takes place without the patient's consent.

The Ombudsman has subsequently opened an own-initiative case against a forensic psychiatric ward and the Ministry of Health about whether – after the above-mentioned amendment to the Mental Health Act of 1 January 2022 – there is authority to carry out seclusion in own room without the patient's consent.

6.2. Is consent being obtained and documented in accordance with applicable rules?

6.2.1. Starting point of the investigation
In Case No. FOB 2020-15 and FOB 2020-25 (in Danish at the Ombudsman's website), the Ombudsman established how staff should obtain and document patients' consent to interventions in the form of transitioning from having their doors locked at the Maximum Security Unit and seclusion in own room.

In connection with the visits in 2021, the visiting teams reviewed records on consent to seclusion in own room or other non-statutory interventions and compared the records with the requirements of valid consent to seclusion in own room etc. The visiting teams also discussed the matters with the psychiatric wards' management, staff and patients.

When is there valid consent for seclusion in own room and other non-statutory interventions?

- The consent must be voluntary and must not have been given under force or threats of force.
- The consent must be based on comprehensive information. As a minimum, information must be given on the following – though without implying that such information is necessarily comprehensive:
  - the contents and meaning of the agreement, including the agreement's consequences (that the patients cannot leave their room or a limited area without prior agreement with the staff)
  - the treatment or safety-related purpose of the agreement
  - the fact that the agreement only applies because the patient has given consent and that the patient can withdraw the consent at any time.
- The information must be given in such a way and to such a degree that the patient – to the extent necessary – understands the contents and meaning of the information.
- Staff must have assessed the patient's ability to make decisions.
- The patient must have access to discuss his or her consent with a patient adviser or guardian representative.

6.2.2. Result of the investigation

The Ombudsman's visiting teams found that no valid consent was obtained to seclusion in own room and other interventions in many cases.

Several psychiatric wards stated that seclusion in own room was used for instance in critical situations when it was not possible to obtain consent from the patient. For example, it could be initiated in order to avoid forced immobilisation of the patient.

The wards also pointed out that there could be instances where consent could not be obtained to for example seclusion in own room because the patient was too unwell to relate to this question.

During nine monitoring visits, the Ombudsman recommended that management ensure that consent to seclusion in own room and other

interventions is obtained and documented in accordance with the requirements set out in applicable rules and practices.

Yours sincerely,

Niels Fenger

Thematic report 2021: Children and young people in secure residential institutions

Contents

3 July 2022

Doc.No. 22/01642-3/KHH/lni

1. Introduction

Children and young people in secure residential institutions was the theme of those monitoring visits (within the theme) that the Ombudsman carried out in the children's sector in 2021 in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

In order to elucidate the year's theme, the Ombudsman carried out monitoring visits to Denmark's eight secure residential institutions, of which two have special secure wards. At the same time, the Ombudsman visited the institutions' in-house schools. Two visits were carried out physically, while six visits were carried out virtually, due to COVID-19. The monitoring visits focused especially on:

- Use of physical force, solitary confinement and search of person and room
- House rules and drugs tests
- Education in in-house schools
- Health services.

2. What have the thematic visits shown?

2.1. Main conclusions

- The visited institutions were generally reflective in relation to the use of physical force and other restrictions of the right to self-determination, and the monitoring visits left the overall impression that the institutions were focused on handling conflicts in a pedagogical, constructive and dialogue-based way.

- The deadline for recording and reporting use of physical force and other restrictions of the right to self-determination was to a wide extent not observed, just as the report forms in several instances did not contain an adequate description of the course of events in connection with the use of physical force or the grounds for why the restriction was necessary.

- Several of the institutions did not in connection with the placement inform children, young people or custodial parents etc. of their rights in relation to the use of physical force and other restrictions of the right to self-determination.

- In practice, the institutions find it difficult to handle the distinction between mandatory and voluntary house rules.

- In relation to the in-house schools, there were a number of problems with agreements etc. between the institution and municipalities that did not fully comply with legislative requirements. There were also challenges with regard to observing the rules on teaching the full range of subjects and number of teaching hours and observing the rules on exemption from lessons in subjects, mandatory tests and the examinations of the Folkeskole (the Danish primary and lower secondary school).

- Not all children and young people were offered screening for uncovering a possible need for a psychiatric evaluation.

2.2. General recommendations

On the basis of the monitoring visits, the Ombudsman generally recommends that the secure residential institutions

- ensure that the deadline is observed for recording the use of physical force and other restrictions of the right to self-determination, and that the deadlines are observed for reporting to and informing the relevant authorities and custodial parents etc.

- ensure that report forms on the use of physical force contain an adequate description of the course of events in connection with the use of force, including a description of how the child or young person was effectively conducted or manually restrained, together with the grounds why the intervention was necessary

- ensure that staff are sufficiently familiar with the Act on Adult Responsibility, including the rules on use of force in schools, and that the institutions have written guidelines on the use of physical force and other restrictions of the right to self-determination

- ensure that – in connection with the placement – children, young people and custodial parents etc. are informed of their rights in relation to the use of force or other restrictions of the right to self-determination, including the right to complain. In this context, the Ombudsman recommends that the institutions consider drawing up written material on rights, including the right to complain, that can be handed out on arrival.

- ensure that it is the manager or deputy manager who decides to place a child or young person in solitary confinement, and that in the absence of the manager it is clear to the staff who has been designated as deputy.

- ensure that the institution's guidelines on solitary confinement describe the key requirements in the applicable rules, including that it must be possible for the child or young person to contact staff during the entirety of

the solitary confinement, and that a psychiatric specialist (or a general medical practitioner) must be summoned, if the child or young person suffers from a mental disorder.

In relation to the in-house schools, the Ombudsman generally recommends that the institutions

- in collaboration with the relevant municipality ensure that the basis for the in-house school in the form of agreements etc. complies with the applicable rules

- ensure that all pupils are taught the full range of subjects and number of teaching 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 teaching hours reduced according to the relevant applicable rules

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

In relation to health, the Ombudsman generally recommends that the institutions

- ensure that all children and young people who on arrival has not already undergone a psychiatric evaluation are offered screening in order to uncover a possible need therefore

- are focused on identifying children and young people who have or are at risk of developing withdrawal symptoms, and that the institutions ensure that relevant treatment of withdrawal symptoms takes place.

The Ombudsman discusses follow-up on the general recommendations with, respectively, the then Ministry of Social Affairs and Senior Citizens (now Ministry of Social Affairs, Housing and Senior Citizens), the Ministry of Children and Education and the then Ministry of Health (now Ministry of Interior and Health). The Ombudsman will also follow up on the general recommendations in connection with future monitoring visits.

The Ombudsman has started a number of own-initiative investigations on the basis of the monitoring visits. One is an investigation of some institutions' use of pedagogical measures that implies, among other things, complete or partial exclusion from association with others. Another investigation concerns a possible connection between the rules on door alarms and locking of rooms at night. And a third investigation concerns the possibility of effecting a

reduction in the number of teaching hours in in-house schools pursuant to a provision in the Folkeskole Act which, according to its text, concerns special schools and special classes. Find further details on this below in item 3.5, item 8.2 and item 11.3.

2.3. Background for the choice of theme and focus areas

In the children's sector, the secure residential institutions, including the special secure wards, have strict regimes compared with other institutions.

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

The placement can take place with a view to observation, treatment or to prevent the child or young person from self-harming or harming other people. The placement can also be a substitute for pre-trial detention or as part of serving a sentence. Special secure wards are aimed at children and young people who have made placement in a secure residential institution unsafe due to previous violent or psychologically deviant behaviour.

In a secure residential institution it is thus allowed to have outer doors and windows constantly locked, there must be TV surveillance in all indoor communal areas and there must be door alarms at the rooms of the children and young people. In addition, these institutions can implement the most wide-ranging measures pursuant to the Act on Adult Responsibility for Children and Young People in Out-of-Home Care (Consolidation Act No. 764 of 1 August 2019), including solitary confinement. On that background, the Ombudsman considers children and young people in secure residential institutions to be an especially vulnerable group whose rights can come under pressure.

In 2017, the Ombudsman paid monitoring visits to six of the eight secure residential institutions. Read the thematic report from 2017.

With the theme in 2021, the Ombudsman wanted to update his knowledge of conditions for children and young people in the secure residential institutions and special secure wards and to follow up on the results from of the monitoring visits in 2017.

Furthermore, on 1 January 2019 a number of new rules were introduced in the Act on Adult Responsibility, applicable to secure residential institutions and special secure wards, including on the following:

- Mandatory written house rules and the option of using force and stipulating suitable reactions to transgressions of the mandatory house rules
- Reduction or loss of pocket money
- Restriction of the access to external communication
- New powers on body search of children or young people
- Possibility of using door alarms at the entrance to the rooms.

On that background, the Ombudsman also wanted to learn about the application of the new rules in the Act on Adult Responsibility.

Lastly, the Ombudsman wanted to examine whether the children and young people attending the secure residential institutions' in-house schools are getting the schooling they are entitled to according to legislation. The Ombudsman also wanted to shed light on the children's and young people's access to health services and the institutions' medicines management.

2.4. How did the Ombudsman proceed?

2.4.1. Material and information in connection with the visits
Prior to the monitoring visits, the Ombudsman received information on a range of the institutions' conditions and specific reports on the use of force and other restrictions of the right to self-determination with a view to shedding light on, among others, the chosen focus areas.

Immediately prior to the monitoring visit, the Ombudsman informed the children and young people of the visit with a view to speaking with as many children and young people as possible. During the monitoring visits, the visiting teams interviewed a total of 55 children and young people aged 13-17 years.

Furthermore, the visiting teams spoke with a number of the children's and young people's relatives, primarily parents (65 relatives in total). In addition, the visiting teams spoke with the institutions' staff, including teachers at the in-house schools and those responsible for medicines, and the monitoring teams also obtained information about the institutions in connection with discussions with management.

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

The Ombudsman's work of preventing degrading treatment etc. pursuant to the Protocol is carried out in 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 medical and human rights expertise. This means, among other things, that staff with expertise in these areas participate on behalf of the two institutes in the planning, execution and follow-up regarding monitoring visits.

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

The Ombudsman's Special Advisor on Children's Issues participates in all visits to the child sector.

2.4.3. List of visits in 2021
On the Ombudsman's website, there is a summary of all monitoring visits carried out in 2021, including the recommendations given to the individual institutions: Monitoring visits in the children's sector, 2021

3. Use of physical force

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

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

However, the use of physical force must only be used as an exception. And the use of physical force must never take the place of care and socio-pedagogical measures. In addition, the use of physical 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 greatest possible regard for the personal integrity of the child or young person. This follows from the general principles for the use of force etc. in the Act on Adult Responsibility.

USE OF PHYSICAL FORCE

Who and what
Staff can *manually restrain* or *conduct* 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*.

Physical force can also be used when the child or young person *breaks mandatory house rules* and use of force is necessary in order to stop it.

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

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

Information
On arrival at the institution, the child or young person and the 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 the right to complain.

The rules in the Act on Adult Responsibility apply to all children and young people who are placed in a secure residential institution.

The rules also apply to children and young people placed at a secure residential institution who attend the in-house schools of the secure residential institution. However, this does not apply to the rules on using physical force to put an end to a violation of the house rules, as the in-house schools are not subject to the rules of the Act on Adult Responsibility regarding mandatory house rules.

3.2. Extent of the use of physical force

The visits generally left the impression that the institutions were reflective in relation to the use of physical force and other restrictions of the right to self-determination, and that they were focused on handling conflicts in a pedagogical, constructive and dialogue-based way with a view to preventing

the use of force etc. They used, among other things, Low Arousal, diversion, staff changes and risk assessments of the young people.

At the time of the visits, the secure residential institutions each had between 10 and 20 places. Prior to the visits, the Ombudsman obtained information about, among other things, the number of physical force incidents in the period 2018-2020. The forwarded information shows that the annual number of physical force incidents varied a great deal from institution to institution, and it was not possible to find an immediate correlation between the size of the institution and the number of force incidents. The annual number of force incidents per institution varied in 2020 from 2 to 115 force incidents.

Several of the institutions informed the Ombudsman that many force incidents were centred on one or a few children or young people.

3.3. Examples of reports

The institutions must record the use of physical force on a specific form. The form appears from Appendix 1 a of the Executive Order on Adult Responsibility for Children and Young People in Out-of-Home Care (Executive Order No. 810 of 13 August 2019).

In connection with the monitoring visits, the Ombudsman obtained the five most recent report forms on the use of physical force. The review of the reports formed a basis for discussions between the visiting teams and the visited institutions during the monitoring visits.

With the exception of one institution, the institutions generally used the correct form to record the use of physical force.

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

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

Then the manager (or deputy manager) of the placement institution must without undue delay, meaning as quickly as possible within 24 hours once the recording has been completed, send a copy of the report form to the placing municipality and inform the custodial parents. By 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).

Review of the received report forms showed that none of the institutions fully observed the deadlines for recording and reporting the use of physical force.

On that basis, the Ombudsman recommended to seven of the eight institutions that they observe the deadlines for recording and reporting the use of physical force.

One institution was recommended to ensure that the custodial parents be informed following a physical force incident, and that this be included in the report form.

On that basis, the Ombudsman generally recommends that the institutions ensure observance of the deadlines for recording use of physical force and the deadlines for reporting to and informing the relevant authorities and custodial parents etc. of uses of force.

Some visited institutions had raised the question of how to understand the deadline for reporting to the social supervisory authority (‘by the end of the month’). On that basis, the Ombudsman raised the question with the Ministry of Social Affairs and Senior Citizens so that the Ministry could consider perhaps clarifying the deadline in the guidance notes to the Act on Adult Responsibility.

3.3.2. Documentation of the use of force

A report must contain a description of what happened in connection with the use of force and the grounds for why the intervention was necessary.

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 conducted or manually restrained are prerequisites for being able to assess whether the use of force was in accordance with the rules in 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 instance how the child or young person had been conducted or manually restrained. Furthermore, some reports did not contain any information on what basis the child or young person was assessed to endanger themselves or others.

The Ombudsman recommended to three institutions that they ensure that the report forms will in future contain an adequate description of the course of

events in connection with the use of physical force and grounds for the measure.

The Ombudsman generally recommends that the institutions ensure that report forms on the use of physical force contain an adequate description of the course of events in connection with the use of force, including a description of how specifically the child or young person was conducted or manually restrained, together with grounds for the necessity of the measure.

3.3.3. Inclusion of the child and young person

Children and young people who have been involved in a use of physical force or other restrictions of the right to self-determination must be informed that the episode has been put on record and of the contents of the report on the episode. They must also be given the opportunity to comment on the episode. This follows from the legislation on adult responsibility.

The visits left the general impression that after a use of force the institutions spoke with the children and young people about the episode. A review of the report forms also showed that in most cases, the child or young person had had the opportunity to comment on the episode, but for several institutions, it did not appear clearly from the report form whether the child or young person had been made aware that the episode had been put on record and been informed of the contents of the report.

The Ombudsman gave no recommendations regarding inclusion of the children and the young people. However, he did point out to several institutions that – in addition to being given the opportunity to comment on the episode in connection with use of force and other restrictions of the right of self-determination – the children and young people must be informed that the use of force etc. has been put on record and of the contents of the report on the episode.

3.4. Knowledge of rules etc.

Children and young people placed in secure residential institutions must be treated with dignity, consideration and in accordance with their rights. To ensure this, it is crucial that staff are familiar with the rules that apply to the use of physical force towards the children and the young people.

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

Written guidelines on use of physical force can in this connection provide support and help in the daily work.

During the monitoring visits, the visiting teams generally got the impression that the institutions were focused on ensuring that staff were familiar – for instance through training courses – with the rules of the Act on Adult Responsibility. However, according to a number of the institutions, there had been challenges in completing relevant training courses on for instance restraining holds for a period due to COVID-19.

The majority of the institutions had written guidelines on the use of physical force. However, the visiting teams got the impression in a number of institutions that staff were not sufficiently aware that the rule of the Act on Adult Responsibility regarding the use of force in connection with violation of house rules does not apply to the in-house schools.

The Ombudsman recommended three institutions to ensure that staff are familiar with those rules of the Act on Adult Responsibility that apply to the use of force in the in-house schools.

Furthermore, the Ombudsman recommended three institutions to ensure that the internal guidelines on the use of physical force describe the central requirements of the applicable rules, while one institution was recommended to continue the work of drawing up written guidelines on the use of physical force.

In the light of this, the Ombudsman generally recommends that the institutions ensure that staff are sufficiently familiar with the Act on Adult Responsibility, including the rules on the use of force in schools, and that the institutions have written guidelines on the use of physical force and other restrictions of the right of self-determination.

3.5. Pedagogical measures

In the work with the children and young people, the institutions use various pedagogical measures. In a number of institutions this includes complete or partial exclusion from association with others, for instance as a consequence of undesirable behaviour on the part of the child or young person.

Thus, some of the institutions use timeout where the child or young person stays in his or her room for upwards of a couple of hours, until he or she has calmed down or changed behaviour. Furthermore, some institutions use behavioural programmes where the child or young person is typically separated from the other children and young people and must for instance reflect on the behaviour which has prompted the programme or must carry out certain activities with an adult. The programme can last a number of days. In a number of cases, the children and young people in two institutions

also had to use a call button and wait for staff to arrive before they were allowed to leave their rooms.

In connection with the visits, there was a discussion with the institutions regarding the various measures but no recommendations were given in this regard, as the Ombudsman instead has discussed the pedagogical measures at a meeting with the Ministry of Social Affairs and Senior Citizens. Subsequently, the Ombudsman has started an own-initiative investigation regarding two institutions' use of the aforementioned forms of pedagogical measures.

3.6. Information on rights

In connection with placement in a secure residential institution, the manager must inform the child or young person and the custodial parents (or the representative of the unaccompanied underage foreign national) of their rights in relation to the use of force and other restrictions of the right to self-determination. Their rights include the right to complain to the National Social Appeals Board or the municipal council, respectively. This follows from the legislation on adult responsibility.

The visits showed that several institutions had not in connection with the placement informed the children, young people and custodial parents etc. of their rights in relation to the use of force etc. In other instances, the information given was not adequate.

The Ombudsman gave three institutions a recommendation aimed at ensuring that, in connection with the placement, custodial parents, guardians and personal representatives 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 to the National Social Appeals Board or the municipal council, respectively. For one of the institutions, this recommendation also included information for the children and young people.

In addition, the Ombudsman gave two institutions a recommendation to ensure that the written information to the children and young people about the Act on Adult Responsibility and their rights in relation to the use of force and other restrictions of the right to self-determination contains an adequate description of the applicable rules.

On that background, the Ombudsman generally recommends that institutions ensure that, on arrival at the institution, the children, young people and custodial parents etc. are informed of their rights in relation to use of force and other restrictions of the right to self-determination, including the right to complain. In this context, the Ombudsman recommends that institutions

consider drawing up written material on rights, including the right to complain, that can be handed out on arrival.

4. Solitary confinement

4.1. The rules

It follows from the Act on Adult Responsibility that children and young people in secure residential institutions and special secure wards can be placed in a specially segregated solitary confinement room when certain conditions are met. Solitary confinement must be carried out in compliance with the general principles for the use of force, cf. above under item 3.1.

SOLITARY CONFINEMENT

When and where
Solitary confinement can be used when there is *imminent danger that the child or young person will self-harm or harm other people*.

The solitary confinement must take place in a room especially designed for that purpose.

Who
A decision on solitary confinement can only be made by *the manager or the deputy manager*.

Duration and supervision
Solitary confinement must be *as brief and gentle as possible*. It must not exceed 2 hours in a secure residential institution and 4 hours in a special secure ward.

The child or young person must be able to summon staff during the whole period of solitary confinement. There must be *continuous supervision* of the child or young person.

Immediately after a decision is taken to place a child or young person with mental disorders in solitary confinement, a psychiatric specialist must be called in, or, if this is not possible, a general medical practitioner.

Documentation and hearing
The institution must *record and report* the use of solitary confinement.

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

4.2. Extent of solitary confinement

Six out of the eight secure residential institutions have solitary confinement rooms. Prior to the visits, the Ombudsman obtained information on, among other things, the number of solitary confinement placements in the period 2018-2020. It appears from the information received that the number at the institutions in 2020 varied from none in three of the institutions to, respectively, 3, 9 and 29 solitary confinement placements in the three other institutions. In a number of instances, the solitary confinement placements concerned the same person.

4.3. Examples of reports

Solitary confinement must be recorded on the same report form – and the same deadline for reporting etc. apply – as with the use of physical force, cf. item 3.3.1 above.

In connection with the monitoring visits, the ombudsman obtained the five most recent report forms on solitary confinement. A review of the reports formed the basis for discussions between the visiting teams and visited institutions during the monitoring visits.

The institutions generally used the correct form to record and report solitary confinement.

4.3.1. Observance of deadlines for recording and reporting solitary confinement

The review of the forwarded report forms showed that none of the institutions fully observed the deadlines for recording and reporting solitary confinement.

The Ombudsman gave four institutions a recommendation to observe the deadlines for recording and reporting solitary confinement, while one institution was recommended to ensure that it is documented that recording and reporting solitary confinement has happened within the deadline.

On that basis, the Ombudsman generally recommends that the institutions ensure that the deadlines for recording a solitary confinement and the deadlines for reporting to and briefing of the relevant authorities and custodial parents regarding the solitary confinement are observed.

4.3.2. Documentation of solitary confinement

In one institution, the Ombudsman gave a recommendation that the institution ensure that reports on solitary confinement contain an adequate description of and grounds for the use of force.

4.3.3. Inclusion of the children and the young people
The review of the report forms on solitary confinement showed that the institution in most cases gave the children or young people the opportunity to comment on the episode. There were, however, several instances where it did not appear clearly from the form whether the child or the young person had been informed that the episode had been put on record and of the contents of the report on the episode.

The Ombudsman did not give any recommendations regarding inclusion of the children and young people. He did, however, point out to several institutions that the children and young people – in addition to being given the opportunity to comment – must also be informed that the episode has been put on record and of the contents of the report on the episode, cf. also item 3.3.3 above.

4.4. Knowledge of rules
During the monitoring visits, the visiting teams got the general impression that managements were focused on ensuring knowledge of the rules on solitary confinement. Furthermore, the majority of the relevant institutions had internal guidelines on solitary confinement.

However, in a number of institutions the visiting teams got the impression that there was some uncertainty as to who can decide to place a child or young person in solitary confinement.

The Ombudsman gave three institutions a recommendation to ensure that it is the manager or the deputy manager who makes the decision to place a child or young person in solitary confinement, and that in the manager's absence it is clear to staff who has been designated as deputy.

In addition, the Ombudsman recommended to two institutions that they ensure that the internal guidelines on solitary confinement describe the central requirements in the applicable rules. Two other institutions were recommended that it appear from the guidelines that it must be possible for the child or young person to contact staff during the entire period of solitary confinement and that a psychiatric specialist (or a general medical practitioner) must be summoned if the child or young person has a mental disorder.

On this background, the Ombudsman generally recommends that the institutions ensure that it is the manager or the deputy manager who makes the decision to place a child or young person in solitary confinement, and that in the manager's absence it is clear to staff who has been designated as deputy.

Furthermore, as appears under item 3.4, the Ombudsman generally recommends that the institutions have written guidelines on the use of physical force and other restrictions of the right to self-determination. In this context, the Ombudsman recommends that the institutions ensure that internal guidelines on solitary confinement describe the central requirements of the applicable rules, including that it must be possible for the child or young person to contact the staff during the whole period of solitary confinement, and that a psychiatric specialist (or a general medical practitioner) must be summoned if the child or young person has a mental disorder.

In connection with the monitoring visits, a number of institutions flagged that – as appeared during monitoring visits in 2017 – there continue to be difficulties in getting a specialist doctor or an emergency services doctor to the institution in connection with the solitary confinement of a child or young person with a mental disorder.

On that background, the difficulties with getting a doctor were discussed at a meeting with the Ministry of Social Affairs and Senior Citizens. The Ministry indicated that it would include the health authorities in a discussion of the problem.

4.5. Conditions during solitary confinement, including supervision etc.
Six out of eight visits took place virtually, and, in relation to the theme, the visiting teams have only inspected the solitary confinement rooms of a single institution (four rooms in total). The solitary confinement rooms had TV surveillance for which there is no authority in the Act on Adult Responsibility. The Ombudsman therefore recommended that the institution cease using TV surveillance of children and young people placed in solitary confinement.

4.6. Information on rights
As appears above under item 3.6, the Ombudsman generally recommends that the institutions ensure that children, young people and custodial parents etc. – in connection with the child's or young person's placement in the institution – 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. In this context, the Ombudsman recommends that the institutions consider drawing up written material on rights, including the right to complain, that can be handed out on arrival.

5. Search of person and room

5.1. The rules

It follows from the Act on Adult Responsibility that secure residential institutions and special secure wards can search a child or young person placed in the institution, or search their rooms, provided certain conditions are met. A search of person and room must be carried out in compliance with the general principles for the use of force, cf. above under item 3.1.

SEARCH OF PERSON AND ROOM

When

Specific reasons:

A search of person and room can be carried out when there are *specific reasons to assume* that the child or young person is in possession of items, where such possession means that order or security cannot be maintained.

Furthermore:

A search can also be conducted of what items a child or young person has on him- or herself or in own room when the child or young person is *placed in the institution*, *before* or *after visits* and *before* and *after absence* from the institution. In these cases, a search can be carried out without a specific reason. It is a condition that the search is necessary in order to ensure that considerations of order or security can be observed.

Who

A decision to search a person or a room is made by *the manager or whoever has the authority to do so*.

How

Before a search, the child or young person generally has the right to be *informed of the reason* for the search. Metal detectors, scanners or the like can be used during the search.

Search of person:

The search may be carried out by *patting the outside of clothes* and *examining pockets and shoes*. The child or young person may be required to take off his or her coat, headgear and shoes. In addition, an *external body inspection may be carried out in the form of examination of the body's surfaces and a search of the clothes*. The child or young person may be required to take his or her clothes off.

Search of room:
When going through the child's or young person's things in the room, the child or young person must generally be offered to *witness the search* or immediately afterwards be offered *a review of the search and its result*.

Documentation and hearing
The institution must *record and report* a search of person and room.

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

Items found during the search can be confiscated if deemed necessary for considerations of order and security. A list must be compiled if items belonging to the child or young person are confiscated. The child or young person must be informed of the confiscation and receive a copy of the list.

5.2. Extent of search of person and room

Prior to the visits, the Ombudsman obtained information about the number of searches of person and room in 2019 and 2020. It appears from the forwarded information that the number in 2020 varied considerably between the institutions – from 19 searches to as much as 236 searches.

According to the information, the institutions typically carry out a search when there are items missing from the kitchen or workshop or when young people get items into the institution from the outside, for instance because the items have been tossed over the fence of the institution. Also changes in the young people's behaviour can give rise to a search, for instance if the young people appear to be under the influence of alcohol or drugs. In addition, a search may be carried out on arrival, after visits, etc.

According to the information, most of the institutions rarely or never use metal detectors, scanners or the like in connection with a search.

5.3. Examples of reports

The same deadlines for reporting etc. searches of persons and rooms apply as for use of physical force, cf. item 3.3.1 above. Which form to use for the report depends on whether it is a search based on suspicion of possession of items (the report form in Appendix 1 a of the Executive Order on Adult Responsibility) or a search in connection with arrival, visit or absence (the report form in Appendix 1 c of the Executive Order on Adult Responsibility).

In connection with the monitoring visits, the Ombudsman obtained the five most recent report forms on searches of persons and rooms. The review of

the reports formed a basis for discussions between the visiting teams and the visited institutions during the monitoring visits.

The institutions used forms to report the searches but the Ombudsman found that not all the institutions used the two forms (1 a or 1 c) correctly.

On that background, the Ombudsman gave a recommendation to three institutions that the institutions use the correct form in the Executive Order on Adult Responsibility for recording and reporting searches of person and room.

5.3.1. Observance of deadlines for recording and reporting searches of person and room

The review of the report forms showed that none of the institutions fully observed the deadlines for recording and reporting searches of person and room.

On that basis, the Ombudsman gave seven out of eight institutions a recommendation to observe the deadlines for recording and reporting searches of person and room.

Furthermore, the Ombudsman gave two institutions a recommendation to ensure that custodial parents are informed following a search of person and room, and that this appears from the report form.

On that background, the Ombudsman generally recommends that the institutions ensure that the deadlines for recording a search of person and room and the deadlines for reporting to and briefing the relevant authorities and custodial parents etc. are observed.

5.3.2. Documentation of search of person and room

Some of the received report forms did not contain an adequate description of the course of events etc. in connection with the search. There was for instance no account of the considerations of order and security that made the search necessary.

The Ombudsman gave two institutions a recommendation with the aim of ensuring that the report forms will in future contain an adequate description of the course of events in connection with a search of a person and room and a reason for the measure.

5.3.3. Inclusion of the child and the young person

The review of the report forms on searches of persons and rooms showed that the institutions in most instances gave the child or young person the opportunity to comment on the episode. However, it did not appear clearly

from the report form in the individual case whether the child or young person had been informed that the episode had been recorded and of the content of the report.

The Ombudsman recommended to one institution that the institution ensure that children and young people following a search of person and room are informed that the episode has been put on record and of the content of the report, and that they are given the opportunity to comment on the episode. Furthermore, the Ombudsman pointed out to several institutions that – in addition to being given the opportunity to comment – the children and young people must also be informed that the episode has been put on record and of the content of the report, cf. also item 3.3.3 above.

5.4. Knowledge of the rules

During the monitoring visits, the visiting teams received the general impression that managements were focused on ensuring a knowledge of the rules on search of person and room.

A number of institutions had internal guidelines on search of person and room. However, the guidelines were in several instances not adequate or clear in relation to central elements in the rules. Among other things, they did not clearly state that a list must be made of the confiscated items belonging to the child or young person, and that the child or young person must be given a copy of the list. Some institutions did not have internal guidelines but stated, among other things, that staff apply the legal basis or are informed of the rules via training courses.

The provisions on search of person and room contain detailed rules, and it may therefore be appropriate to have internal guidelines in this regard, similarly to guidelines on the use of physical force and solitary confinement.

On that background, the Ombudsman recommended to three institutions that they consider drawing up internal guidelines on search of person and room.

In addition, the Ombudsman gave three institutions a recommendation with the aim of ensuring that the institutions' internal guidelines on search of person and room describe the central requirements in the applicable rules.

As appears above under item 3.4, the Ombudsman generally recommends that the institutions have written guidelines on the use of physical force and other restrictions of the right to self-determination, including search of person and room.

5.5. Information on rights

As appears above under item 3.6, the Ombudsman generally recommends that the institutions ensure that – in connection with the child or young person being placed in the institution – children, young people and custodial parents etc. 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. In this context, the Ombudsman recommends that the institutions consider drawing up written material on rights, including the right to complain, that can be handed out on arrival.

6. House rules

6.1. The rules

The manager of a secure residential institution and special secure ward must lay down a written set of house rules, setting out detailed rules and guidelines for residing in the institution (mandatory house rules). It appears from the Executive Order on Adult Responsibility what a set of mandatory house rules must contain.

In addition, other rules can be laid down in a set of house rules (voluntary house rules). These rules must be driven by objective considerations and must not go further than what the purpose of the placement institution dictates. There must not be a disproportionate restriction of the rights of the children and young people.

Generally, the established house rules must apply to everyone residing in the institution, unless there are objective reasons for making exceptions.

HOUSE RULES

Mandatory part

Mandatory house rules must as a minimum contain rules on:

1. wake-up time between 06:00 and 09:00 on weekdays
2. wake-up time between 08:00 and 11:00 on weekends
3. bedtime between 21:00 and 23:00 on weekdays
4. bedtime between 22:00 and 24:00 on weekends
5. quiet in the rooms between bedtime and wake-up time, cf. No. 1-4
6. mandatory participation in classes, treatment and other scheduled activities
7. good behaviour in communal areas, meaning behaviour that does not cause inconvenience to the community or to the safety or security of the children and young people placed in care, and a behaviour

without unacceptable language usage and where violent, offensive or noisy behaviour is unacceptable
8. ban on consuming and possessing alcohol and euphoriant drugs
9. smoking ban, with the exception of specified outdoor areas within the institution's premises
10. visits, including time period, duration and good behaviour on the part of the visitors.

Wake-up times and bedtimes may be departed from in holiday periods.

Additionally, the house rules must contain rules to the effect that telephone conversations and other electronic communication must only take place in specific areas of the institution and during specific time periods.

The house rules may also contain rules that the children and young people placed in the institution must hand over their own mobile telephones and other electronic communication devices to the staff who will store them during the placement.

Information
The house rules must be *written down*. The children and young people must be made aware of the house rules.

Appropriate reactions
Staff can stipulate appropriate reactions to violations of mandatory house rules. The reaction must have a pedagogical and educative purpose and must be laid down in accordance with, among other things, the general principles for use of force and other restrictions of the right of self-determination.

Reduction or loss of pocket money
On grosser or repeated violations of the mandatory house rules, the child or young person may have his or her pocket money reduced or lose it for a period of time. A decision to do so must be made by the placing municipality.

6.2. Implementation of mandatory house rules etc.

In connection with the monitoring visits, the visiting teams focused on whether the institutions had included the mandatory house rules in their house rules, and whether the other house rules were driven by objective considerations.

The visiting teams received the general impression that the institutions informed the children and young people of the house rules, and that the house rules were also handed out in most cases to the children and young people on arrival.

Furthermore, it was the general impression that there was a great deal of focus on ensuring compliance with the house rules through dialogue with the children and the young people instead of using reactions, and that any reactions regarding violations of the mandatory house rules were adapted to individual considerations for the children and young people. The institutions did not seem to make use of the possibility of asking the municipality to make a decision on reduction or loss of pocket money.

The Ombudsman gave no recommendations concerning the institutions' house rules but did point out to a number of institutions that they should review the house rules with a view to ensuring, among other things, that the mandatory rules are in accordance with the statutory authority given by the Executive Order on Adult Responsibility.

The completed visits generally showed that the distinction between the mandatory house rules and the voluntary house rules was in practice difficult to handle, and that the implementation of the mandatory rules presents challenges, not least when the institutions make textual adaptions to the mandatory rules in the house rules. In addition, the visiting teams saw that the same reactions were used for violations of, respectively, mandatory and voluntary house rules.

The challenges of implementing the mandatory house rules have been discussed at a meeting with the Ministry of Social Affairs and Senior Citizens.

7. Drugs tests

7.1. The rules

According to the Act on Adult Responsibility, secure residential institutions and specially secure wards can use drugs tests when certain conditions are met.

When
Staff can use a drugs test when a child or young person suffers from *drug abuse* or there are *specific reasons to assume that the child or young person has ingested drugs*.

General consent
Before a drugs test is taken, the child or young person *must have given a general consent* to the use of the test. For children under the age of 12, the custodial parents must have given a general consent.

The consent must be *informed, voluntary and explicit*. A general consent can always be *withdrawn* by the child or the young person and by the custodial parents.

Voluntary participation in specific test
The *participation of the child or young person in the drugs test must be voluntary* in the specific situation. The child or young person must not suffer any negative consequences if he or she will not submit to the test.

Briefing
The custodial parents and the placing municipality must always be informed that a drugs test has been used in a specific situation and be informed of the result of the test. The briefing can take place orally.

7.2. The use of drugs tests

The majority of the institutions do not keep statistics of the drugs tests they carry out but, according to their information, most of the institutions use drugs tests to a limited extent.

During the monitoring visits, the visiting teams received the general impression that the institutions were focused on ensuring that drugs tests are used in accordance with the rules thereon, including that a general consent for a drugs test is given to a relevant extent, for instance in connection with the placement. It was also the general impression that in the specific situation the test is only carried out if the child or young person participates voluntarily.

There was also a general focus on the requirement that the custodial parents and the placing municipality be informed when a test has been carried out and of the result of the test.

The Ombudsman recommended to one institution to ensure that, to a relevant extent, a general consent is obtained to the use of a drugs test from the children and young people placed in the institution, either on arrival or during the placement, if the need to use tests arises. The institution was also recommended to ensure that the child's or young person's placing municipality is informed that a drugs test has been used and of the result of the test.

A number of the institutions had internal guidelines concerning drugs tests. However, it was found that the guidelines of some of these institutions were not adequate on all points in relation to central requirements in the applicable rules.

On that background, the Ombudsman recommended that two institutions ensure that the internal guidelines on drugs tests describe the central requirements in the applicable rules.

8. Door alarms and locking of doors at night

8.1. The rules

In secure residential institutions and special secure wards, door alarms must be placed at the entrance to the rooms of the children and young people placed in the institution. Door alarms must be used in compliance with the general principles of the use of force, cf. item 3.1 above.

DOOR ALARMS

How
Door alarms must be placed at the entrance to the rooms of the children and young people. The alarms must be able to register whether anybody goes in or out through the rooms' doors but not who it is. Staff will be alerted when the door to a room is opened.

Who
A decision to use door alarms – meaning whether to switch on/activate the installed door alarms – is made by *the manager or the deputy manager*.

When
Door alarms can be used when it is *necessary in order to ensure that house rules or security considerations are observed*.

In addition, door alarms must always be used in certain specified situations, among other things when it is necessary for the sake of the child's or young person's own safety or when there has been physical conflict between the children and young people, which makes continued presence in communal areas unsafe.

The duty to use door alarms does not apply in periods when secure residential institutions and special secure wards have permission to lock the doors at night.

Documentation
There is *no duty to record and report* the use of door alarms.

According to the Executive Order on Adult Responsibility, the social supervisory authority can give secure residential institutions and special secure wards permission to lock the rooms of the children and young people at night for considerations of order and security.

8.2. Use of door alarms

The monitoring visits left the general impression that door alarms are used to a limited but varying extent, depending on, among other things, the physical setting and the specific composition of the group of children and young people placed in the institution. One institution informed the Ombudsman that the introduction of the rules on indoor TV surveillance has reduced the need for using door alarms.

On the basis of information received in connection with the monitoring visits of a varying practice on the part of the social supervisory authorities, the Ombudsman has started an own-initiative investigation towards the Ministry of Social Affairs and Senior Citizens on whether there may be assumed to be a correlation between the rules on door alarms and the locking of doors at night.

9. Access to external communication

Children and young people who have been placed in secure residential institutions and specially secure wards due to reasons pertaining to criminal law (surrogate custody, serving a sentence or a youth sanction) may be subject to restrictions in the access to communication and the internet. The relevant rules do not apply to children and young people who have been placed at the institution for welfare reasons or for reasons pursuant to the Aliens Act.

However, the house rules in secure residential institutions and special secure wards may contain rules that the children and young people placed in the institution must hand over their own mobile telephones and other electronic communication devices to staff who will store it during the placement. All the secure residential institutions had a rule on handing over telephones etc. on arrival.

When implementing such a rule, it must, however, be taken into account that the children and young people placed in the institution due to reasons of

welfare or pursuant to the Aliens Act must have access to conduct telephone conversations and have other electronic communication without that communication being overheard or monitored by staff or other children and young people placed in the institution.

The monitoring visits in the secure residential institutions showed that all institutions to a certain extent allowed access to telephone communication for the children and young people placed in the institution for reasons of welfare or pursuant to the Aliens Act. Most institutions also allowed access to the internet. In some institutions, the children and young people had access to their own telephone in a separate room and at certain specific times. In other places, the children and young people had, within certain limits, access to communication via equipment in the institution. The Ombudsman pointed out to one institution that, aside from telephone access, the children and young people placed in the institution for reasons of welfare or pursuant to the Aliens Act should also to a certain extent have access to the internet (other electronic communication).

10. Use of door frame scanner etc. for visitors

To check visitors, one of the institutions used a door frame scanner installed in the door frame of the visiting room. If the scanner reacted, the visitors would be checked by for instance patting their pockets, and they might be asked to take their shoes off or to empty their pockets, and a hand-held scanner might also be used.

The Ombudsman has taken a position on a secure residential institution's use of a door frame scanner etc. in a previous case (FOB 2020-20, published on the Ombudsman's website, in Danish only). The responsible ministry stated in connection with this case that, when an opportunity arises, the ministry would create the authority for the secure residential institutions to use door frame scanners to check visitors and their effects.

As such authority has not been created yet, the Ombudsman recommended to the institution using scanners to check visitors that it cease this practice.

The Ombudsman informed the Ministry of Social Affairs and Senior Citizens thereof in a meeting.

11. Education in in-house schools

11.1. The rules

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

The rules on primary and lower secondary school education appear from the Danish Folkeskole Act (Act on the Danish Municipal Primary and Lower Secondary School) with related executive orders and guidelines. Among other things, an executive order has been issued on special education and other kinds of special pedagogical assistance under the Act in day-care and placement institutions.

Children and young people attending an in-house school are entitled to the same education as children and young people attending a Folkeskole (a Danish primary and secondary state or municipal school). 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 their class hours reduced in accordance with applicable rules.

11.2. Agreements etc. with municipalities, including PPR services

All eight secure residential institutions have an in-house school, and the Ombudsman's monitoring visits included all these schools. Seven of the eight institutions are run by the regions while the last institution is run by a municipality.

In relation to the in-house school, the region-run secure residential institutions must have entered into an agreement with the municipality of location. There are a number of elements that such an agreement must contain as a minimum, including regulation of the Pedagogical Psychological Counselling services (PPR – Pædagogisk Psykologisk Rådgivning services).

The monitoring visits showed that there are generally challenges of ensuring that the agreements live up to the minimum requirements for their contents.

Thus, the Ombudsman gave a recommendation to six institutions with the aim that the institutions, in cooperation with the municipality of location, ensure that the agreement is in accordance with the applicable rules. The municipality-run institution was recommended to ensure, in cooperation with the municipality, that there is approval of the in-house school in accordance with the applicable rules.

The Ombudsman generally recommends that the secure residential institutions, in cooperation with the relevant municipality, ensure that the

basis for the in-house school in the form of agreements etc. is in accordance with the applicable rules.

In relation to the PPR services, the visiting teams found that different models are used in this respect. In some places, the PPR services are run by the region instead of the municipality while in one of the institutions, according to the received information, an in-house psychologist was in charge of the PPR services.

In continuation of a previous year's monitoring visits, the Ombudsman has started an own-initiation investigation on the PPR services at an independent institution with an in-house school. In connection with the investigation, the Ministry of Children and Education has made a general statement on the rules for PPR services. The Ministry has stated that it is the municipality of location that has the final responsibility for PPR services to placement institutions etc. in the municipality, and that this also includes the cost connected with PPR. In addition, the Ministry has stated that it depends on the general framework of administrative law pertaining to delegation to what extent others than the municipality can be in charge of parts of the PPR services. A news item on the case has been published on the Ombudsman's website, in Danish only.

Further to the monitoring visits to the secure residential institutions, the Ombudsman has written to the relevant municipalities that the Ombudsman assumes that the municipality will ensure that PPR services in relation to in-house schools, and the agreements with the institutions on the running of the in-house schools, are in accordance with the statements from the Ministry of Children and Education on the rules on Pedagogical Psychological counselling services.

11.3. Teaching a full range of subjects and number of teaching hours, exemption from subjects and exemption from tests and examinations

As was the case in 2017, the Ombudsman's monitoring visits in 2021 show that it is still a challenge for in-house schools in secure residential institutions to observe the rules on teaching a full range of subjects. Furthermore, there were challenges with observing the rules on exemption from lessons in subjects and from mandatory tests and the Folkeskole examinations.

It was the visiting teams' general impression that the challenges were mainly due to the children's and the young people's educational level and other circumstances in the form of, among other things, addiction and mental disorders. In addition, it presented a difficulty for the institutions because the young people were typically only in the institution for a short time.

Furthermore, it was the impression that the institutions are familiar with the rules on exemption from subjects etc. but seldom make use of them. In this connection, the institutions stated that exemption is subject to a difficult process in the light of the short period of time that the young people are placed at the facilities.

The Ombudsman recommended to all eight institutions that they ensure compliance with the rules on teaching the full range of subjects, and he recommended to six institutions that they comply with the rules on teaching the full number of hours. In addition, one institution was recommended to ensure that one-to-one lessons comply with the applicable rules.

In addition, the Ombudsman recommended to six institutions that they ensure compliance with the rules on exemption from lessons in subjects while one of the other institutions was recommended to ensure that a decision on exemption from lessons in subjects is made on the basis of a PPR assessment. Furthermore, the Ombudsman recommended to all eight institutions that they ensure compliance with the rules on exemption from mandatory tests and Folkeskole examinations.

The Ombudsman generally recommends that it is ensured in relation to in-house schools that all pupils are taught the full range of subjects and number of hours, and that exemption from this is only made if – based on a specific and individual assessment – a pupil is exempted from lessons in one or more subjects or has the class hours reduced according to the applicable rules.

Additionally, the Ombudsman generally recommends that it is ensured that decisions on exemption from mandatory tests and the Folkeskole examinations are made in accordance with the rules, and that this is documented.

In a meeting with the Ministry of Children and Education, the Ombudsman gave a general account of the continued challenges for the in-house schools in the secure residential institutions and special secure wards.

During the monitoring visits, it came to the Ombudsman’s attention that two municipalities with regard to two in-house schools had decided to approve an application for reduction in the number of teaching hours according to a provision in the Folkeskole Act, which according to its text concerns special schools and classes.

The Ombudsman has started an own-initiative investigation on the subject.

12. Health

12.1. 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.

During the visits, the visited institutions accounted for the children's and young people's access to health services, including treatment by general medical practitioner, dentist and specialist doctors. The visits generally left the impression that the institutions were focused to a relevant extent on the children's and young people's health-related conditions and their access to health services, and that the institutions followed up on any medical challenges in an appropriate way.

A number of the institutions stated that the children and young people typically keep their own general medical practitioner during the placement, which can present challenges in relation to getting them seen by a doctor if there is no arrangement with a doctor in the local area.

The Ombudsman recommended to two institutions that they consider making an arrangement with a local doctor who can assist with the treatment of the children and young people as long as they are residing in the institution in question. In addition, one of these institutions was also recommended to consider how to ensure to a greater extent that children and young people have access to regular dental check-ups.

12.2. Screening etc.

Children and young people placed in a secure residential institution or a special secure ward and not already having undergone a psychiatric evaluation must be offered a screening with a view to uncovering a possible need for a psychiatric evaluation. This appears from the Executive Order on Adult Responsibility.

In connection with the monitoring visits, the visiting teams discovered that a number of institutions do not offer such a screening in all relevant instances. The impression was that there were doubts on, among other things, whether unaccompanied underage foreign nationals must be offered screening.

The Ombudsman gave a recommendation to five of the institutions with the aim of ensuring that children and young people are offered a screening to uncover a possible need for a psychiatric evaluation if they have not already undergone such an evaluation on arrival at the institution.

The issue of screening has been discussed at a meeting with the then Ministry of Social Affairs and Senior Citizens. The Ministry has expressed its agreement with the Ombudsman in that everyone – also unaccompanied underage foreign nationals – must be offered screening.

In the light of this, the Ombudsman generally recommends that the secure residential institutions ensure that all children and young people are offered a screening to uncover a possible need for a psychiatric evaluation if they have not undergone such an evaluation on arrival at the institution.

Some of the institutions indicated that they experience challenges in relation to receiving untreated young people with severe mental problems. One of the institutions stated that they do not always feel equipped to receive these young people, and that the condition of several of the young people are not sufficiently evaluated. At the same time, some institutions experience challenges regarding cooperation with the emergency psychiatric services when the institutions contact them.

The Ombudsman recommended to two institutions that the institutions consider discussing the possibility of a cooperative agreement with the child and adolescent psychiatry services on, among other things, admissions and discharges.

In a meeting, the Ombudsman has drawn the attention of the then Ministry of Social Affairs and Senior Citizens to the challenges experienced by the institutions in relation to receiving and working with children and young people with severe mental problems.

12.3. Medicines management, addiction etc.

Correct medicines management is crucial to patient safety, and the Danish Health Authority has issued national clinical guidelines on drawing up instructions and on prescription and management of medicines.

No recommendations were given to institutions regarding their medicines management, but two of the institutions were given recommendations concerning their instructions on medicines management.

The secure residential institutions and special secure wards can receive children and young people who may have taken drugs or who have an actual addiction and who are therefore at risk of experiencing withdrawal symptoms during their placement. On this background, it is important that the institutions take this into account.

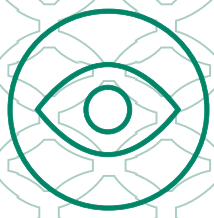
The Ombudsman recommended to three institutions that they ensure that the institutions are focused on identifying – perhaps through a drugs test – young

people who on arrival have, or are at risk of developing, withdrawal symptoms, and to ensure that treatment of the withdrawal symptoms take place. In addition, one institution was recommended to consider drawing up written guidelines on detection and treatment of drug abuse etc., including withdrawal symptoms.

The Ombudsman generally recommends that the secure residential institutions are focused on identifying children and young people who have or are at risk of developing withdrawal symptoms, and that the institutions ensure that relevant treatment of withdrawal symptoms takes place.

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 before the authorities; 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 special 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 others, 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 there is a basis for further investigation of a matter. 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 the case can 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.