FOLKETINGETS OMBUDSMAND

Annual Report 2022

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 2022 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 2022 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 2022. The thematic report regarding adults concerns conditions for new remand prisoners. The thematic report regarding children concerns small private accommodation facilities for young people.

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 2022 in full.

Part One

Extract from the Danish Parliamentary Ombudsman's Annual Report 2022

Monitoring activities

Where: The Ombudsman carries out monitoring visits to places where there is a special need to ensure that citizens are treated with dignity and consideration and in accordance with their rights by the authorities – because the citizens 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, to persons with disabilities.

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

- The Ombudsman carries out monitoring visits in accordance with section 18 of the Ombudsman Act to especially institutions where people 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 (IMR), 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 is 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 a member of the Ombudsman's staff being present during the whole or part of the deportation. The Ombudsman also reviews the case files of a number of the deportation cases concluded during the preceding year.

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

Who: Monitoring visits are carried out by Ombudsman staff, in many cases with participation of external collaborative partners or consultants. 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
- a consultant who has a mobility disability
- a consultant who has a visual disability

Where did we go in 2022?

Monitoring visits – adults

14 Prison and Probation Service institutions, including 1 in the Faroe Islands

12 police detention facilities and custody reception areas, including 4 in the Faroe Islands

2 psychiatric wards

1 social residential facility

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

Monitoring visits – children

9 private accommodation facilities

2 boarding schools

Themes

Theme in 2022 – adults

New remand prisoners' conditions
In 2022, the Ombudsman's thematic visits (adults) were focused on conditions for new remand prisoners.

The visits concerned the police's arrests and transfers of prisoners to the Prison and Probation Service as well as the Prison and Probation Service's reception of new remand prisoners.

As part of the theme, the Ombudsman visited eight local prisons and eight police districts.

Focus areas
During the thematic visits in 2022, the visiting teams focused particularly on

- the police's guidance on and ensuring of the rights and safety of arrestees
- the police's handing over of relevant information on transfers of arrestees to the Prison and Probation Service
- the local prisons'
  - talks on arrival and other guidance on new arrestees' rights and on guidelines for the stay in the local prison etc.
  - uncovering of conditions relevant to arrestees' safety and state of health
  - screening for mental health issues
  - information on the local prison's health services and the option to talk with a physician or nurse
  - ensuring arrestees' rights, including contact to relatives, lawyers etc.
  - communication of relevant information to and from social authorities etc.

Examples of recommendations
During some of the visits to the police districts, the Ombudsman recommended that the police ensure that there is documentation of the arrestees having been informed of their rights.

In connection with the visits to local prisons, a number of recommendations were given on subjects within the year's theme. For example, the Ombudsman recommended that managements of local prisons ensure

- that inmates are given adequate guidance on their rights etc. on reception
- that inmates get a knowledge of the local prison's rules, including its house rules, and practical matters on reception
- the use of an interpreter to the necessary extent on reception of new inmates
- that staff receive guidance on or training in uncovering mental health issues, including thoughts of suicide

Follow-up
In the course of 2023, a thematic report will be published, which 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.

The thematic report will be discussed with key authorities within the police and the Prison and Probation Service.

Theme in 2022 – children

Small private accommodation facilities for young people
In 2022, the Ombudsman's thematic visits (children) were aimed at young people at small private accommodation facilities – meaning accommodation facilities with eight to ten places, as a starting point.

As part of the theme, the Ombudsman visited eight small private accommodation facilities with primarily young people aged 13-17 years in residence.

Focus areas
During the thematic visits in 2022, the monitoring teams focused particularly on

- use of physical force
- returning runaways
- detaining in connection with or during placement
- searches of persons and rooms
- drug testing
- prevention and handling of alcohol and drug addiction, sexual abuse and self-harming behaviour

Examples of recommendations
In connection with the visits, recommendations were given on subjects within the year's theme – for instance, the Ombudsman recommended that accommodation facilities

- ensure that staff are familiar with the rules on use of physical force and other interventions, including on how physical force should be carried out in practice
- ensure that deadlines for recording and reporting use of physical force are observed
- ensure that the young people and their parents are informed of their rights in relation to use of force and other interventions
- ensure that consent is obtained to use of drug testing, and that the municipality and the parents are informed about use of drug testing and the result of the test

In the course of 2023, a thematic report will be published, which 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.

Read about themes at en.ombudsmanden.dk/themes

The Ellebæk Centre for Foreigners is in better condition but there is still a need for improvement

Monitoring visit: In 2019, the Ombudsman visited the Ellebæk Centre for Foreigners and recommended that the condition of the Centre be improved so that the detainees would have adequate material conditions.

When the Ombudsman revisited Ellebæk in September 2022, he found that thorough renovations had been carried out, and that by far the majority of the accommodation units were in good condition. The outdoor areas had also been improved, but the Ombudsman recommended that focus remain on continuing this task. The detainees had access to playing fields together with the centre's staff and could also go outside for fresh air on their own, but in small enclosures with walls and top made of a rigid metal mesh, and there was no roof to protect against rain or direct sunlight.

The detained foreign nationals at Ellebæk come from many different countries and speak many different languages. It is therefore important that interpreters are used in all circumstances when needed – the Ombudsman recommended that the centre's management ensure this.

It also emerged during the visit that – despite management having focused on the issue – there could be episodes where staff talked among themselves or to the detainees in an unprofessional or 'harsh' way. The Ombudsman therefore recommended a continued focus on the staff's way of talking.

News item 6 December: The Ellebæk Centre for Foreigners is in better condition but there is still a need for improvement

Use of force did not give rise to any comments

Forced deportation: The Parliamentary Ombudsman monitors authorities' forced deportations of foreign nationals who do not have lawful residence in Denmark. The Ombudsman oversees if the authorities' activities take place with respect for the individual and without unnecessary use of force.

On 29 March 2022, one of the Ombudsman's legal case officers monitored the accompanied deportation of a woman and two of her children to Iran. The legal case officer was there from the pick-up at the Danish Red Cross Centre Avnstrup until the boarding of the flight at Copenhagen Airport. The deportation was subsequently cancelled during transit in Istanbul.

The deportation gave rise to discussions in the media because force was used against the woman and because information came out stating that the authorities allegedly used sedatives during the deportation.

Based on observations of the authorities' handling of the deportation and the information in the case, the Ombudsman concluded that the police's use of force during the deportation did not give rise to any comments. In addition, the Ombudsman noted that there were no observations or information in the case about use of medication or other kinds of sedatives during the deportation.

Pedagogical-Psychological Counselling (PPR) is a municipal responsibility

PPR assessments: When a pupil needs special education, pedagogical-psychological counselling must first be provided, and the pupil and the parents must be consulted. This is pursuant to the Act on Primary and Lower Secondary Education ('Folkeskoleloven'). The pedagogical-psychological counselling is necessary to ensure that among others children and young people placed in care outside the home receive the right educational programme.

In connection with a monitoring visit to an independent institution with an in-house school, the Ombudsman became aware that pursuant to an agreement with Næstved Municipality the task of making PPR assessments was carried out by a special needs adviser employed by the institution. This could be supplemented by buying psychological counselling from the municipality. However, the issue was if an employee with the institution could be in charge of making the assessments or if it was the municipality's responsibility to carry out the task.

The issue was if an employee with the institution could be in charge of making the assessments.

The Ombudsman asked the Ministry of Children and Education to say whether it is a municipal responsibility to provide pedagogical-psychological counselling to a placement institution.

The Ministry replied that the municipality has the final responsibility for the pedagogical-psychological counselling and that it rests on the general delegation framework pursuant to administrative law to what extent others than the municipality (for instance independent institutions) can carry out parts of the pedagogical-psychological counselling. The municipality must determine whether the requirements necessary for a delegation have been met. This means, among other things, that if parts of the PPR task – for instance making a PPR assessment – are given to others, the municipality must ensure that these others possess the necessary professional expertise.

On that basis, the municipality implemented a process to ensure that it lived up to the municipal obligation in relation to the PPR task .

Door alarms could not replace locking of doors

Secure residential institutions: Secure residential institutions can be given permission to lock the doors of the institution's young people at night for considerations of order and security. In connection with some of his monitoring visits, the Ombudsman noticed that the social supervisory authorities had a varying practice for giving such a permission. One social supervisory authority had revoked two institutions' permission due to new rules on the use of door alarms. The social supervisory authority believed that the possibility of installing door alarms on the young people's doors could replace the locking of doors at night. Another social supervisory authority did not believe that the possibility of using door alarms changed the need for locking of doors.

The Ombudsman asked the Ministry of Social Affairs and Senior Citizens (now the Ministry of Social Affairs, Housing and Senior Citizens) to consider the correlation between locking of doors and door alarms. The Ministry replied that the door alarms were to be considered a supplement and not a replacement for locking the doors at night. The social supervisory authority that had revoked the permissions then decided to look into the cases again.

The social supervisory authorities had a varying practice for giving permissions.

Monitoring visit to the Faroe Islands

Medical attention: In the summer of 2022, the Ombudsman carried out a monitoring visit on the Faroe Islands, which included the police detention facilities and waiting rooms as well as the Faroe Islands detention centre ('Færøerne Arrest'). The Ombudsman's impression of the visited places was generally positive, but he also had certain comments and recommendations. For example, the visits to the detention facilities led to recommendations on surveillance of detainees who are too intoxicated to take care of themselves. The recommendations concerned the police's duty, already during transport to the facility, to summon a doctor who can examine the detainee and to watch the detainee closely until the doctor arrives.

The purpose of the Ombudsman's monitoring visit is to help ensure that people who are deprived of their liberty by the police or the prison and probation service on the Faroe Islands are treated with dignity, consideration and in accordance with their rights.

The Ombudsman's impression of the visited places was generally positive.

2022

Ten years with a Children´s Division

Lise Bitsch
Deputy Head of Division

Susanne Veiga
Senior Head of Division

The Children's Division tries to help as many children and young people as possible and has a special focus on the vulnerable ones.

In April 2013, the Ombudsman's Children's Division was on a monitoring visit to a residential institution in Esbjerg Municipality. Here, the visiting team met two socially vulnerable children who were siblings.

After the monitoring visit, the Children's Division started a case regarding the municipality's performance prior to the children being placed in care. It turned out that the municipality had not taken any real initiatives to help the siblings, despite having received 11 serious notifications of concern from, among others, police, school and citizens in the course of a year. The children were six and eight years old when the municipality received the first notification of concern. It was not until one of the two siblings, now nine years old, was admitted to hospital with a blood alcohol level of 2.57 per mille that the children were put into emergency care outside the home. The children had – as shown – received help from the municipality far too late, and the Ombudsman stated that the municipality's neglect was 'completely indefensible'.

The case arose from one of the first monitoring visits carried out by the Children's Division, and it is thankfully a rarity among the various types of cases processed by the Ombudsman's Children's Division. In 2022, it was ten years since the Division opened its doors for the first time. In the following, we will take a look at some of the contributions of the Children's Division and the effect thereof.

But let us start with a bit of history.

The Children's Ombudsman Cooperation

In connection with the establishment of the Children's Division, Children's Welfare in Denmark and the National Council for Children were also strengthened. The Children's Division, Children's Welfare in Denmark and the National Council for Children constitute the Danish Children's Ombudsman Cooperation.

With the Children's Telephone ('BørneTelefonen'), Children's Welfare in Denmark has an 'entrance portal', which most children in Denmark know.

The National Council for Children makes surveys with and about children and is an advocate for children's rights in Denmark. Through its investigation of complaints and monitoring activities, the Children's Division helps to ensure that children's rights are respected.

So the Danish Children's Ombudsman Cooperation does not consist of one body but of three bodies, each doing what they do best, and together constituting a fundamental support for children in Denmark.

The establishment of a Children's Division

When Parliament about ten years ago decided to establish a Children's Division within the Parliamentary Ombudsman Office, it was based on a recommendation from the UN Committee on the Rights of the Child and on a wish to strengthen the conditions and legal rights of children.

Case processing in the Children's Division

Case processing takes place within the scope of the Parliamentary Ombudsman Act. This means that the Children's Division basically considers legal questions and can only investigate a case when all other channels of complaint have been exhausted. When investigating a case, the focus is on whether or not the Ombudsman can help with the result. Help can also consist of getting the case back on track with the authority or by getting the authority to expressly consider specific grievances.

The Children's Division particularly investigates concrete cases on:

- remedial measures and social benefits for children and young people
- cases involving family proceedings
- state, continuation and private independent schools
- institutions for children
- other cases which specifically concern the rights of children.

The task of the Children's Division is to help ensure that both public authorities and private institutions etc. treat children and young people in accordance with the rules, both Danish and international, including the UN Convention on the Rights of the Child.

The Children's Division does so by investigating concrete complaints. The complaints are lodged by both children and adults (though by far the majority are from adults). When children and young people apply to the Children's Division, the case officers quickly take care of it, often through an initial contact over the telephone, followed up by a reply that is written in a way that children can understand.

The Children's Division can also go on monitoring visits to institutions etc. for children and young people and take up cases on its own initiative, for instance following media coverage or based on monitoring visits.

The Ombudsman also investigated cases regarding the rights of children and young people before the Children's Division opened on 1 November 2012. However, with the establishment of the Children's Division, efforts in this important field have been strengthened.

Vulnerable children and young people

All children and young people may need help to ensure that their rights are respected, and the Children's Division tries to help as many children and young people as possible. However, the Children's Division has a special focus on vulnerable children and young people, such as children and young people placed outside the home.

When children are moving back home

Over the years, the Children's Division has processed a number of cases about municipalities

which have moved or have wanted to move children and young people in care back to their parents (return to home). Returning a child (or a young person) who has been in care greatly affects the child's future life. The municipality must therefore ensure that it is the right solution for the child and that the parents are able to safeguard the child's well-being and development in future. Furthermore, the child may be trapped in a conflict of loyalty in relation to the parents if the child does not wish to return home. That is why there are a number of statutory requirements regarding municipalities' case processing.

If a municipality wants to return a child placed in care to the parents, the municipality must have a talk with the child and work out an action plan, which to a relevant degree stipulates among other things the future support for the child (and the parents) following the return. A young person over the age of 12 must receive a decision from the municipality with grounds and guidelines on making a complaint so that the young person can complain about the municipality's decision if he or she disagrees.

A review of seven specific return cases in Randers Municipality and Langeland Municipality in 2018 and 2020 showed that all cases contained serious errors – both in relation to conducting a talk with the child, revision of the young people's action plans and (adequate) grounds for the decision to return the child or young person to the home and guidelines on making a complaint for young people over the age of 12. The Ombudsman expressed serious criticism regarding these deficiencies. And both municipalities subsequently explained how they would ensure that cases involving the return to the home of children and young people placed in care would in future be processed in accordance with legislation.

Conditions in placement facilities etc.
In connection with the Ombudsman's monitoring activities, the Children's Division often visits institutions, accommodation facilities etc. for socially vulnerable children and young people. During the monitoring visits, the Children's Division is normally focused on the use of physical force and other restrictions in the right to self-determination, the children's relationships with staff, education and activities, and health-related conditions.

A broader aim

The Children's Division is not focused solely on helping individual children and young people experiencing problems, but also on pointing out systemic errors by the authorities that have an impact on a number of cases or an entire case field and thereby on a larger group of children. An issue in a specific case or a specific situation may thus be an expression of a more general error (systemic error) or a lack of legal clarity.

Right to an education
Education is an important part of the foundation for all children's footing as adults. The Children's Division has therefore had a focus on education, among other things in-house schools in placement facilities for children and young people, with a view to ensuring that the in-house school pupils get the education they are entitled to. After several examples showing that this was not the case, the Ombudsman raised the issue generally with the (now) Ministry of Children and Education. In March 2022, a political agreement was established on strengthening education for vulnerable children and young people placed in care.

Rights of pupils
In the field of education, the Children's Division has received many complaints about the rights of pupils when a school resorts to serious reactions,

such as expulsion. On that background, the Ombudsman raised the issue with the (now) Ministry of Children and Education. The Ministry then implemented further guidance measures to ensure that school principals apply the rules of administrative law correctly. In the field of private independent schools and continuation schools, the result of the Ombudsman's comments to the Ministry about the issue was that on 1 January 2021, new rules came into force which made it clear that schools must include (consult) a pupil and document this inclusion before a decision to expel the pupil can be made.

Consultation on the child's terms

When a child or young person is to be consulted as a party to the case, it must be done in such a way that the child understands what the case is about, and the approach must be considerate towards the child. This was a key message in a specific case regarding the National Social Appeals Board's consultation with (among others) a 12-year-old child diagnosed with autism. The Board had sent the child a consultation letter with documents from the case and asked the child for 'any comments within 8 days'.

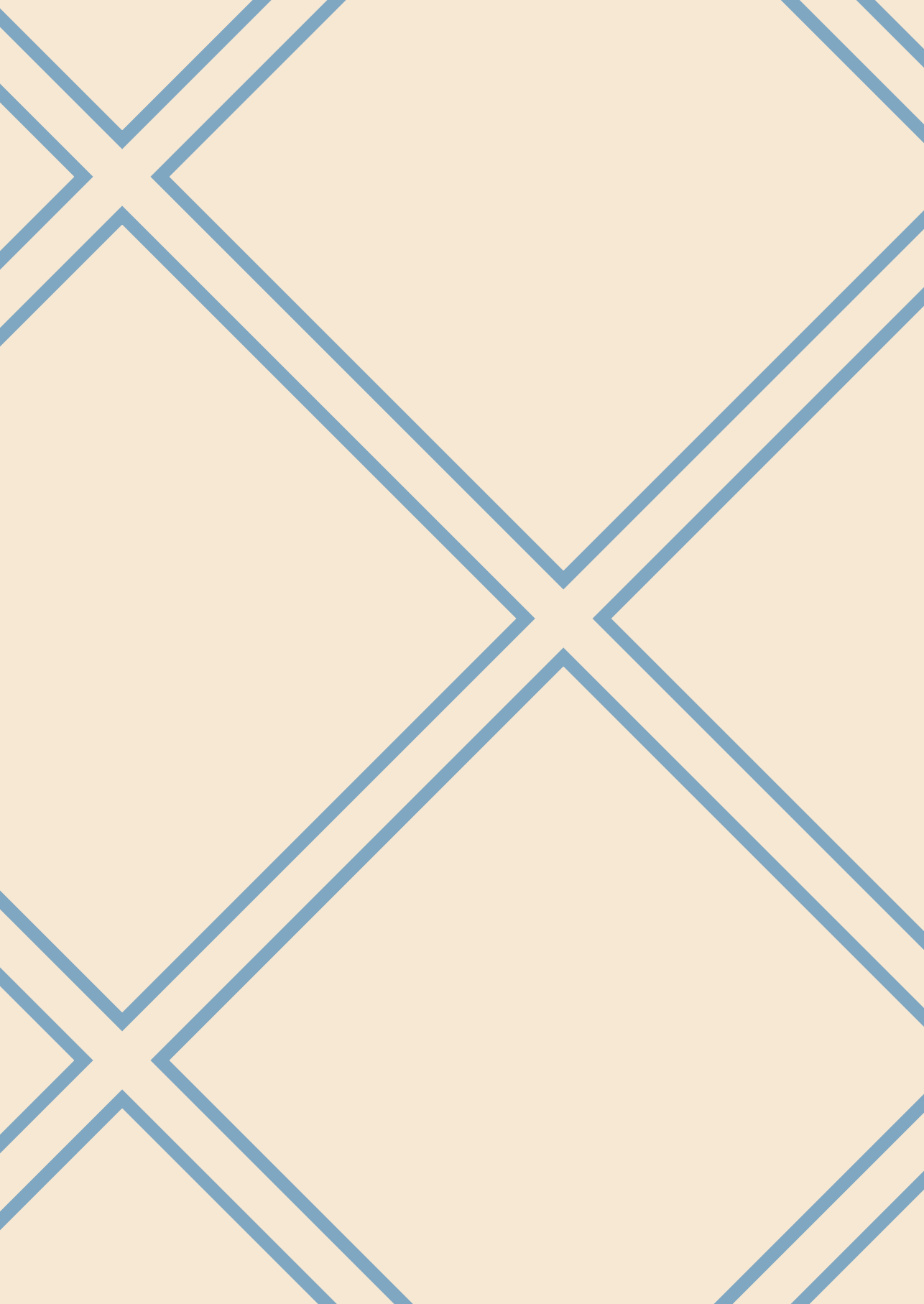
Serious issues

The cases in the Children's Division often contain basic legal issues. For instance, there was a case where in practice there were doubts as to what rules applied to forcible placement in care of asylum-seeking children whose parents did not have a legal residence permit in Denmark (for instance rejected asylum seekers).

Following the Ombudsman's enquiry of the (now) Ministry for Social Affairs and Housing whether the legal basis for forcibly placing asylum-seeking children in care was sufficient, Parliament in 2020 adopted new rules on social measures towards children of parents without a legal residence permit in Denmark.

Further work

The first ten years have shown that there is plenty to do for a Children's Division with the Parliamentary Ombudsman. This holds true both in relation to ensuring concrete help for individual children and young people but also in relation to dealing with general errors or legal uncertainties, which can have an impact on many children or on a whole case field. The Children's Division will continue its work of helping the children – with a continued focus on the vulnerable children, including those who are placed outside the home and who maybe need to be helped towards a good life under somewhat more difficult conditions than other children of the same age.



Force and non-statutory interventions in the psychiatric sector

Camilla Bang
Deputy Head of Department

Morten Engberg
Senior Head of Department

The Ombudsman's investigations show that psychiatric wards should continue to have focus on the legal framework for use of force and non-statutory interventions.

Admission, stay and treatment in a psychiatric ward are generally voluntary. However, if a citizen does not want to take part, both admission and treatment can take place by force when the conditions of the Mental Health Act are met. The Act also makes it possible for psychiatric ward staff to use forcible measures such as manual restraint of the patient and belt restraints.

Non-statutory restrictions and interventions in the psychiatric sector

In addition to the forcible measures mentioned in the Mental Health Act, psychiatric patients are subject to restrictions and interventions in their right to self-determination that are not mentioned in the legislation.

These could be restrictions that are found in the psychiatric wards' regular house rules – such as rules about visitation hours, when a ward should be quiet and where smoking is allowed. There can also be restrictions that a ward is in practice imposing on the patients, without them appearing in the ward's house rules.

As such, an institution's management can, to a certain extent, establish house rules or other restrictions to ensure that the institution can function. The basis is the unwritten principle of institution status.

However, in some cases, a non-statutory restriction is so intrusive for the patient that it cannot be carried out with authority in the principle of institution status, but requires consent from the patient. In these instances, the ward must ensure that the patient gives valid consent that is voluntary and informed. Otherwise, it is force, which requires statutory authority. The patient must also know that the consent can be withdrawn at any time.

The Ombudsman's monitoring in the psychiatric sector

During monitoring visits to psychiatric wards, the Ombudsman is regularly informed about various kinds of non-statutory restrictions and interventions that are used towards the patients.

- The Ombudsman monitors, among other things, how the authorities treat citizens who are deprived of their liberty. Therefore, the Ombudsman regularly visits the psychiatric wards.
- The monitoring visits are carried out in cooperation with the Danish Institute for Human Rights and with DIGNITY – Danish Institute Against Torture. The two institutions cooperate with the Ombudsman in the monitoring field.
- During monitoring visits, the Ombudsman focuses on whether the basic principle of the patient's right to self-determination is observed, meaning that the patients are only subjected to force if there is legal authority.

In several cases, the Ombudsman has made the health authorities aware that the legal basis for restrictions and interventions was questionable. In Case No. 2020-43 (published in Danish at www.ombudsmanden.dk), which concerned 17 psychiatric wards, the Ombudsman questioned the legality of, for instance, restricting the patients' access to a mobile phone, prohibiting sexual relations between patients and the wards' use of breathalysers and urine sampling.

This case and several other cases are described in more detail in the article 'Monitoring activities: Institution status may provide questionable legal authority' in the Ombudsman's 2020 Annual Report.

In 2021, the Ombudsman's monitoring visits focused especially on the use of non-statutory restrictions and interventions in the psychiatric sector. The Ombudsman visited ten psychiatric wards, and it turned out that almost all of them used interventions with a questionable legal basis. The Ombudsman recommended that nine of the ten psychiatric wards adjust their house rules and practice according to the applicable rules.

Amendment to the Mental Health Act

The Ombudsman has in several instances discussed the non-statutory restrictions and interventions that are used towards psychiatric patients with the Ministry of Health and Senior Citizens (now the Ministry of the Interior and Health).

In order to create more clarity for both patients and staff, the Minister for Health introduced a bill at the end of 2021 about amendment to the Mental Health Act. The amendment, which entered into force on 1 January 2022, describes what prohibitions and restrictions of the patients' right to self-determination that the psychiatric wards can introduce in their house rules. With the amendment, the wards are able to, for instance, prohibit or restrict the patients' access to a mobile phone and sexual relations between patients at the ward. It is also possible to require a patient to submit urine samples or blow into a breathalyser, for instance on suspicion of drugs at the ward.

The amendment has thus created a more clear legal basis in a number of areas.

Continued focus

However, the new rules of the Mental Health Act do not cover all kinds of restrictions and interventions.

During his monitoring visits, the Ombudsman has paid attention to the use of what is referred to as 'seclusion in own room'. This entails that the patient is isolated in a limited area, such as their room, with an unlocked door and possibly

with one or more members of staff standing guard outside the door. Several psychiatric wards have stated that seclusion in own room is used in critical situations, for instance in order to avoid forced immobilisation of a patient, and that it is often difficult to obtain valid consent from the patient in the situation.

In 2020, the Ombudsman considered the use of seclusion in own room in Case No. 2020-25. He agreed with the former Ministry of Health and Senior Citizens that requiring a patient to stay in his or her room without the patient having given consent was a forcible measure, which at the time did not have authority in the Mental Health Act.

The Ombudsman has recently in a specific case about seclusion in own room also agreed with the Ministry of the Interior and Health that neither the amendment to the Mental Health Act of 1 January 2022 nor the principle of institution status provides the necessary authority for seclusion in own room without consent from the patient.

If non-statutory restrictions or interventions cannot be made pursuant to the principle of institution status, the ward must ensure that the patient has given voluntary consent and has also been informed that the consent can be withdrawn at any time.

The Ombudsman will also in future pay attention to the use of non-statutory restrictions and interventions in the psychiatric sector.

The experience of a monitoring visit – a talk with Consultant Psychiatrist Hans Henrik Ockelmann

Martin Østergaard-Nielsen
Special Communications Advisor

As a consultant with a long career in the psychiatric sector, Hans Henrik Ockelmann has on several occasions experienced a visit from staff members from the Parliamentary Ombudsman's Monitoring Department. And he is generally positive towards the function served by the monitoring visits. Even though he must admit that it can also be stressful when 'you come poking the ant hill', as Ockelmann, now 65 years old and a consultant in forensic psychiatry at Mental Health Centre Sct. Hans, says with a twinkle in his eye.

'The Parliamentary Ombudsman is after all an institution that commands respect. Maybe even a little intimidating. And you ask for a lot of documentation when you visit. Especially if there is a specific theme you wish to explore. I am not saying your questions are not relevant because they definitely are. But it is no secret that they also generate a certain workload. It takes a lot of energy to have the Ombudsman visiting.'

Monitoring those in control

The Ombudsman's monitoring visits are meant to ensure that persons deprived of their liberty, at psychiatric hospitals for instance, are treated with dignity, consideration and in accordance with their rights. And to Hans Henrik Ockelmann, this exact purpose is the most important function of the monitoring visits.

'It is necessary to monitor those in control of others,' he says. 'This applies on a personal level as well of course. On a daily basis, I find myself in a position where I am monitored very little. It is of course nice but it can also be a little dangerous in the long run. Therefore, it is good that somebody is looking over your shoulder. When you are in a powerful position, complacency benefits from a bucket of ice-cold water.'

However, Ockelmann does state that the Ombudsman's visits sometimes reveal a schism between what he calls 'the legal requirements' and everyday life at the hospital.

About

- Hans Henrik Ockelmann, aged 65
- Consultant in forensic psychiatry at Mental Health Centre Sct. Hans
- Doctor of Medicine (MD), University of Copenhagen 1985

'Here, it is our continuous task to make everyday life work for everybody and to find soft and dynamic solutions to issues to which the law most likely has a more rigid approach.'

As an example, Ockelmann mentions the balancing between the interests of the community and of the individual in the establishing of a calm and accommodating environment at the psychiatric ward.

'In this connection, I sometimes experience what could be called a clash between two mindsets. The Ombudsman must ensure that the legislation is observed. And legislation is by and large centred on the individual. But in everyday life at the ward, we have to find solutions to situations where some patients exhibit behaviour that is disruptive or anxiety-provoking for the whole group. And those two considerations may very well collide in the practical logistics of social interactions at the ward.'

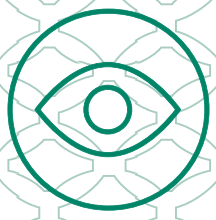
Ockelmann adds that the Ombudsman's staff members generally are knowledgeable of and attentive to the conditions at the institutions.

'We do have some good dialogue, and it is my impression that you always listen to our points of view. Even when you are not convinced in the end.'

Feel taken seriously

According to Hans Henrik Ockelmann, a very important element of the Ombudsman's work is to talk to those who live at the institutions, be they prisons or psychiatric hospitals or something completely different.

'It has been of great importance to the patients at the monitoring visits I have seen. They feel they are being taken seriously in a way that might be quite new to them. They are often vulnerable people on the edge of society. And when they get the opportunity to talk with the Ombudsman and make complaints or wishes for improvements, they get the feeling someone really listens to them.'



Part Two

Overview of factual information regarding the individual monitoring visits and recommendations

Overview: Monitoring visits to institutions for adults in 2022

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, residents, patients etc.) and with relatives etc. (relatives, guardians, social guardians of persons under a residential care order and patient advisors). Lastly, the table shows the recommendations given to the individual institution. Under the OPCAT[1], the Ombudsman collaborates with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights (IMR), which participate in monitoring visits, among other things.

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

MONITORING VISITS	NO. OF VISITS
NO. OF VISITS	29
TALKS WITH USERS	119
TALKS WITH RELATIVES ETC.	5
WITH DIGNITY	29
WITH IMR	15
ANNOUNCED/UNANNOUNCED VISITS	29/0
CONCLUDED WITH RECOMMENDATIONS	23
CONCLUDED WITHOUT RECOMMENDATIONS	6

MONITORING VISITS

Renbæk Prison
2 February
6 closed units as well as disciplinary and solitary confinement section
Talks with 21 users
DIGNITY participated

Recommendations

- That management ensure that, on reception, inmates are made aware of the prison's rules, house rules and practical matters.
- That management maintain focus on the relational work between staff and inmates as well as ensure that inmates get replies to requests etc. and understand the decisions made by the prison.

Western Prison ('Vestre Fængsel')
Reception unit
2 March
Talks with 10 users
DIGNITY and IMR participated

Recommendations

- That management ensure continued focus on inmates receiving sufficient guidance about their rights etc. on reception.
- That management consider how to ensure that inmates are familiar with the plan for the inmates' stay in the custody of the Prison and Probation Service, cooperation with other authorities etc. (the action plan).

Copenhagen Police
Detention facility and waiting room at Station Bellahøj
3 March
Talk with 1 user
DIGNITY and IMR participated

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

Western Copenhagen Police
Detention facility and waiting room at Albertslund Police Headquarters
7 March
No talks with users or relatives
DIGNITY and IMR participated

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

'Hillerød Arrest'
Remand unit
15 March
Talks with 3 users
DIGNITY participated

Recommendations

- That management ensure that the deadlines for making action plans in Circular No. 9741 of 28 June 2022 are met.
- That management ensure that health-related documentation, including documentation of the initial health assessment, is comprehensive and meets the formal requirements for record keeping.
- That management ensure that the house rules are translated into relevant languages.

North Zealand Police
Detention facility and waiting room, Station Nord
16 March
No talks with users or relatives
DIGNITY participated

Recommendations

- That management ensure that the frequency of supervision and supervision of arriving detainees is in accordance with applicable rules.

Mental Health Services South, Vordingborg
Psychiatric bed unit for geriatrics
30 March
Talks with 2 users and 3 relatives
DIGNITY participated

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

'Odense Arrest'
Remand unit
5 April
Talks with 7 users
DIGNITY and IMR participated

Recommendations

- That management ensure continued focus on inmates receiving sufficient guidance about their rights on reception.
- That management ensure that, on reception, inmates are made familiar with the house rules, and that the house rules are available to all inmates.
- That management ensure a relevant amount of guidance about the special complaints scheme and access to judicial review under Section 778 of the Administration of Justice Act, for instance by including this guidance in the house rules' section about complaining.
- That management, in a way deemed relevant, ensure that healthcare staff are informed of inmates in solitary confinement.

Funen Police
Detention facility and waiting room, Funen Police Headquarters in Odense
6 April
No talks with users or relatives
DIGNITY and IMR participated

Recommendations

- That management ensure continued focus on filling in all items in the detention report, including justifying if some items are not filled in.
- That management ensure that there is a procedure for control with calling systems in the detention facility and waiting room.

'Aarhus Arrest'
Remand unit
11 May
Talks with 8 users
DIGNITY participated

Recommendations

- That management consider how to ensure that inmates are familiar with the plan for the inmates' stay in the custody of the Prison and Probation Service, cooperation with other authorities etc. (the action plan).
- That management ensure that the short version of the house rules is translated into relevant languages.
- That management ensure the removal of the requirement that a request for a talk with healthcare staff must be justified on an open request form.
- That management ensure that the room used for temporary detainment of new inmates (the former exercise room) is set up in a way that avoids the risk of inmates self-harming.

- That management ensure that the exercise room is again being used as an exercise room as soon as possible.

East Jutland Police
Detention facility and waiting room, Aarhus Police Headquarters
12 May
Talk with 1 user
DIGNITY participated

Recommendations

- That management ensure that supervision of arriving detainees is in accordance with applicable rules.
- That management ensure that the item in the detention report concerning the handing out of a folder with guidance about complaining, among other things, is filled in.

'Aalborg Arrest'
Remand unit
16 May
Talks with 3 users
DIGNITY participated

Recommendations

- That management take care to ensure the necessary confidentiality and discretion in the healthcare services, including in connection with talks in double cells and submission of request forms.
- That management ensure increased focus on correct, precise and comprehensive documentation in reports on placement in an observation cell.
- That management ensure that the house rules are translated into relevant languages.
- That management ensure use of interpreters to the necessary extent.
- That management ensure that calls for toilet visits are answered as quickly as possible.
- That management ensure that both inmates and staff share an understanding that it is acceptable for inmates to call in order to go to the toilet.
- That management ensure that staff – unless for control purposes – always knock on inmates' cell doors before opening.

North Jutland Police
Detention facility and waiting room, Aalborg
17 May
No talks with users or relatives
DIGNITY participated

Recommendations

- That management ensure that it is documented that arrestees have been informed of their rights; cf. Circular No. 9155 of 18 March 2010.

Police on the Faroe Islands
4 monitoring visits to the Police on the Faroe Islands:

- **Detention facility and waiting room in Tórshavn**
- **Waiting room at Vágar Airport**
- **Detention facility in Klaksvík**
- **Detention facility in Tvøroyri**

30 May – 2 June
No talks with users or relatives
DIGNITY and IMR participated

Combined report

Recommendations

- That management ensure that the local instructions 'Guidelines and procedures in connection with arrestees and detainees' and 'Guide for placement in waiting rooms' are updated so they are in accordance with applicable rules and practices and so it is clearly stated:
    - what rules apply to placement in detention facilities and waiting rooms and
    - who – at police stations where the officer in charge is not present – is responsible for carrying out the tasks of the officer in charge.
- That management ensure the drawing up of procedures for ongoing control of the electronic equipment in detention facilities and waiting rooms, including smoke detectors and calling systems.
- That management ensure that the supervision of detainees is carried out in accordance with the rules of the Executive Order on detention facilities, including that increased supervision before the medical examination is carried out and that, after the medical examination, supervision is only carried out via listening and surveillance devices when the conditions for this are met.
- That management ensure that medicine is only handed out according to a doctor's instructions and consider if there is a need to draw up instructions for medicines management.
- That management ensure that, already during transport of intoxicated detainees, a doctor is summoned in order to examine the detainee, unless the transport is of short duration.
- That management ensure that all relevant items in the detention report are filled in.

'Færøerne Arrest'
Remand unit
3 June
Talks with 7 users
DIGNITY and IMR participated

Recommendations

- That management – for instance in connection with the coming into force of the Sentence Enforcement Act – review the house rules in order to ensure, for example:
    - that the house rules are in accordance with applicable rules
    - that the house rules to the relevant extent contain a description of underlying rules and complaint options
    - that the various language versions of the house rules have the same contents.

'Pension Hammer Bakker'
General units, resettlement day release unit and family unit
8 June
Talks with 4 users
DIGNITY participated

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

'Psykiatri Nord, Thy-Mors'
General psychiatric bed unit, Thisted
9 June
Talks with 2 users
DIGNITY participated

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

'Esbjerg Arrest'
Remand unit
15 June
Talks with 8 users
DIGNITY and IMR participated

Recommendations

- That management ensure continued focus on inmates receiving sufficient guidance about their rights on reception.
- That management ensure relevant guidance about the special complaints scheme and access to judicial review under Section 778 of

the Administration of Justice Act, for instance by including such guidance in the house rules.
- That management ensure that medicines management lives up to the requirements of applicable rules and guidelines.
- That management ensure that the health-related record-keeping lives up to the requirements of applicable rules and guidelines.

South Jutland Police
Detention facility and waiting room, Esbjerg Police Headquarters
16 June
No talks with users or relatives
DIGNITY and IMR participated

Recommendations
- That management ensure that arrestees are informed of their rights etc. and that this is documented; cf. Circular No. 9155 of 18 March 2010.

Ellebæk Centre for Foreigners
Centre for foreigners
6 September
Talks with 4 users
DIGNITY and IMR participated

Recommendations
- That management have continued focus on improving the outdoor areas.
- That management ensure use of interpreters to the necessary extent.
- That management ensure that there is increased attention on ensuring that the rules on solitary confinement are applied correctly, including distinguishing between temporary exclusion from association under Section 63(3) and interrogation cell under Section 71(1) of the Sentence Enforcement Act.
- That management have continued focus on ensuring that staff have a professional tone of communication mutually and towards detainees.

'Nykøbing Mors Arrest'
Remand unit
4 October
Talks with 7 users
DIGNITY participated

Recommendations

- That management ensure that, on reception of new inmates, staff receive guidance or training in uncovering mental health conditions, including thoughts of suicide.
- That management ensure the use of interpreters to the necessary extent, including in connection with talks relating to reception and healthcare as well as talks on uncovering mental health conditions.
- That management ensure that both inmates and staff share an understanding that it is acceptable for inmates to call in order to go to the toilet and that urine bottles are not handed out unless requested.

'Holstebro Arrest'
Remand unit
5 October
Talks with 4 users
DIGNITY participated

Recommendations

- That management ensure that staff receive guidance or training in uncovering mental health conditions, including thoughts of suicide, on the reception of new inmates.
- That management ensure the use of interpreters to the necessary extent, including in connection with talks relating to reception and talks on uncovering mental health conditions.
- That management ensure that inmates do not have the impression that use of an overnight urine bottle is mandatory.

Central and West Jutland Police
Detention facility in Holstebro
6 October
Talk with 1 user
DIGNITY participated

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

'Frederikshavn Arrest'
Remand unit
12 October
Talks with 9 users
DIGNITY and IMR participated

Recommendations

- That management ensure that cell calls are answered as quickly as possible and within reasonable time.

- That management ensure that the exercise room is not being used for accommodation.
- That management ensure a well-functioning library scheme.

'Hobro Arrest'
Remand unit
13 October
Talks with 10 users
DIGNITY and IMR participated

Recommendations

- That management ensure that cell calls are answered as quickly as possible and within reasonable time.
- That management ensure that both inmates and staff share an understanding that it is acceptable for inmates to call in order to go to the toilet and that urine bottles are not handed out unless requested.
- That management ensure that staff – unless for control purposes – knock on inmates' cell doors before opening.

'Botilbuddet Granvej'
Accommodation facility for citizens with mental health challenges combined with active drug abuse
20 December
Talks with 7 users and 1 relative
DIGNITY participated

Recommendations

- That management draw up a policy concerning violence and threats between and against residents which relates to
    - preventive measures
    - the handling of victim, offender and any affected co-residents in connection with a specific episode
    - follow-up with victim, offender and affected co-residents
    - the handling of violence and threats from outside persons.

Overview: Monitoring visits to institutions etc. for children in 2022

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 relevant, 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 recommendations made in connection with the individual visit are presented.

MONITORING VISITS	NO. OF VISITS
NO. OF VISITS	11
TALKS WITH USERS	68
TALKS WITH RELATIVES ETC.	41
WITH DIGNITY	10
WITH IMR	4
ANNOUNCED/ UNANNOUNCED VISITS	10/1
PHYSICAL/ VIRTUAL VISITS	10/1
CONCLUDED WITH RECOMMENDATIONS	10
CONCLUDED WITHOUT RECOMMENDATIONS	1

MONITORING VISITS

'Soranahus', Tølløse
(virtual visit)
19-20 January
Private accommodation facility
Talks with 6 users and 6 relatives
DIGNITY and IMR participated

Recommendations
The visiting team recommended that 'Soranahus':

- Consider giving staff a course on the rules of adult responsibility legislation, including the interface between care and force.
- Ensure that report forms on use of physical force are filled in correctly.
- Ensure that the internal guidelines on use of physical force, detainment in connection with or during placement and searches of persons and rooms are in accordance with applicable rules.
- Ensure that the internal guidelines on returning runaways describe the central requirements in applicable rules.

'Bækkely Fonden', Kettinge
Private accommodation facility
28 February and 1 March
Talks with 5 users and 7 relatives
DIGNITY participated

Recommendations
The visiting team recommended that 'Bækkely':

- Ensure that young people and custodial parents are informed of their rights in relation to use of force and other restrictions of the right to self-determination, including access to complain to the National Social Appeals Board and the municipal council, respectively, in connection with the young people's arrival to the facility.
- Observe deadlines for recording and reporting use of physical force.
- Ensure that report forms on use of physical force are filled in correctly, including that custodial parents have been informed.
- Update the internal guidelines on use of physical force and on searches of persons and rooms so they describe the central requirements in legislation.
- Consider giving staff a course on the rules of adult responsibility legislation, including how physical force should be carried out in practice.

- Ensure that staff are familiar with signs of sexual abuse and the procedure in connection with suspicion of abuse, for instance by elaborating on the relevant internal guidelines.
- Ensure that the facility's instructions and practice concerning medicines management follow the applicable guidelines, including with respect to dispensing of PRN medicines.

'Opholdsstedet Herbertgaard', Jerslev
Private accommodation facility
15-16 March
Talks with 5 users and 3 relatives
DIGNITY participated

Recommendations
The visiting team recommended that 'Herbertgaard':

- Ensure that report forms on use of physical force and searches of persons and rooms are filled in correctly.
- Revise the house rules so they target the young people, and in that connection ensure that the house rules do not contain provisions that constitute restrictions of the right to self-determination that are in violation of applicable rules.
- Ensure that staff are aware that the Act on Adult Responsibility does not apply to young people in aftercare.

'Bostedet Viljen i/s', Gandrup
Private accommodation facility
16-17 March
Talks with 3 users and 2 relatives
DIGNITY participated

Recommendations
The visiting team recommended that 'Viljen':

- Revise the guide 'Information on use of force' so it concerns the rules of adult responsibility legislation.
- Ensure that report forms on use of physical force and searches of persons and rooms are filled in correctly.
- Observe deadlines for recording and reporting searches of persons and rooms.
- Continue the work of ensuring that staff are sufficiently familiar with the rules of adult responsibility legislation, including on use pf physical force, and in that connection ensure that the internal guidelines on use of physical force are in accordance with and describe the central requirements in legislation.

- Ensure that the internal guidelines on searches of rooms describe the central requirements in adult responsibility legislation and consider also drawing up internal guidelines on searches of persons.
- Ensure that the placing municipality is informed of use of a drug test and the results of the test.
- Ensure that no restrictions of the right to self-determination are carried out that exceed the extent allowed by the adult responsibility legislation, and that any consent to restrictions of the right to self-determination is voluntary.

'Opholdsstedet Vitus ApS', Haslev
Private accommodation facility
4-5 April
Talks with 7 users and 6 relatives
DIGNITY and IMR participated

Recommendations
The visiting team recommended that 'Vitus':

- Continue the work to ensure that young people and custodial parents are informed of their rights in relation to use of force and other restrictions of the right to self-determination, including access to complain to the National Social Appeals Board and the municipal council, respectively, in connection with the young people's arrival to the facility.
- Ensure that the deadlines for recording and reporting use of physical force are observed and that the report forms are filled in correctly.
- Ensure that young people, after a physical force incident, are informed of the contents of the report thereon and have an opportunity to comment on the episode.
- Ensure that custodial parents and the placing municipality are informed of use of a drug test in accordance with the adult responsibility legislation as well as the results of the test.
- Ensure that the facility's smoking policy is in accordance with the Act on Smoke-Free Environments.

'Opholdsstedet Frejas Have', Kerteminde
Private accommodation facility
3-4 May
Talks with 3 users and 3 relatives

Recommendations
The visiting team recommended that 'Frejas Have':

- Ensure that staff are familiar with rules on use of physical force, including how physical force should be carried out in practice.

- Ensure that young people and custodial parents are informed of their rights in relation to use of force and other restrictions of the right to self-determination, including access to complain to the National Social Appeals Board and the municipal council, respectively, in connection with the young people's arrival to the facility.
- Ensure that the deadlines for recording and reporting use of physical force and searches of persons and rooms are observed and that the report forms are filled in correctly.
- Consider drawing up written guidelines on searches of rooms that describe the central requirements in legislation.
- Ensure that, to a relevant extent, general consent from the young people is obtained for use of drug tests, either in connection with the arrival or during the placement, if a need for testing arises.

'Ringe Kost- og Realskole', Ringe
Independent day and boarding school (socio-educational boarding school)
4-5 May
Talks with 11 users and 5 relatives
DIGNITY and IMR participated

Recommendations
The visiting team gave no recommendations.

Own-initiative case involving the Ministry of Social Affairs, Housing and Senior Citizens with inclusion of the Ministry of Children and Education about the basis for use of force at placement facilities under Section 66(1)(viii) (continuation schools, independent vocational schools and independent day and boarding schools) and the scope of the Executive Order on measures for the promotion of good order in the Folkeskole.

'Opholdsstedet Nordtofte', Gilleleje
Private accommodation facility
24-25 August
Talks with 5 users and 5 relatives
DIGNITY participated

Recommendations
The visiting team recommended that 'Nordtofte':
- Ensure that staff are familiar with rules on searches of rooms and use of physical force, including how physical force should be carried out in practice.
- Update the internal guidelines on use of physical force and on searches of persons and rooms so they describe the central requirements in legislation.

- Ensure that, to a relevant extent, general consent from the young people is obtained for use of drug tests, either in connection with the arrival or during the placement, if a need for testing arises.
- Ensure that the placing municipality is informed of use of a drug test and the results of the test.
- Ensure that children, young people and custodial parents are informed of their rights in relation to use of force, including access to complain, when the children and young people arrive at the facility.
- Ensure that applicable guidelines for healthcare-related activities are observed, including medicines management, unintentional incidents and instructions and supervision of staff.

'Opholdsstedet Jupiter'
Private accommodation facility
20-21 September
Talks with 7 users and 1 relative
DIGNITY participated

Recommendations
The visiting team recommended that 'Jupiter':

- Ensure that young people and custodial parents are informed of their rights in relation to use of force and other restrictions of the right to self-determination, including access to complain to the National Social Appeals Board and the municipal council, respectively, in connection with the young people's arrival to the facility.
- Ensure that all force incidents are recorded and reported and that the report forms are filled in correctly.
- Ensure that the deadlines for recording and reporting use of physical force are observed.

'Kostskolen i Sønderjylland', Toftlund
Independent day and boarding school (socio-educational boarding school)
27-28 September
Talks with 10 users and 1 relative
DIGNITY and IMR participated

Recommendations
The visiting team recommended that 'Kostskolen i Sønderjylland':

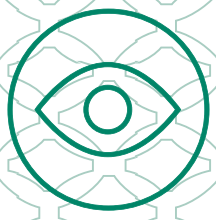
- Ensure that staff are familiar with the facility's procedures for use of force and handling of violence and sexual abuse.
- Draw up a procedure for medicines management that is in accordance with the relevant applicable rules and ensure that medicines management takes place in accordance with those rules.

'Joanna', Vesterborg
Private accommodation facility
In-house school
15-16 November
Talks with 6 users and 2 relatives

DIGNITY participated

Recommendations
The visiting team recommended that 'Joanna':

- Ensure that all staff, including staff in the in-house school and substitute teachers, are familiar with the rules on use of force in the Act on Adult Responsibility and with the Act on Social Service's rules on use of force in relation to young people under 18.
- Ensure that all force incidents are recorded and reported.
- Update the guidelines for use of physical force with the adult responsibility legislation's rules on deadlines for briefing custodial parents and for reporting as well as making it clear that the children and young people must be informed of the contents of the reporting.
- Ensure that the deadlines for recording and reporting use of physical force are observed.
- Update the guidelines on searches of rooms so they describe the central legislative requirements and consider drawing up guidelines on searches of persons.
- Draw up written guidelines on prevention of violence and sexual abuse and on the procedure in connection with suspicion of abuse.



Part Three

Thematic reports 2022

Thematic report 2022: Conditions for new remand prisoners

Contents

26 June 2023

Doc.No. 23/00193-1/UL/skh

1. Introduction

The Ombudsman's monitoring visits to institutions for adults in 2022 focused on conditions for new remand prisoners.

For remand prisoners who have not previously been imprisoned, the local prison is their first encounter with the Prison and Probation Service. The starting point of the investigation is conditions for new prisoners who, following arrest and questioning by the police, have been remanded in custody at a preliminary examination in court. Because of the close connection with the arrest, the investigation has also included relevant conditions for arrestees in police custody and the transfer from the police to the local prison.

Therefore, the investigation has been directed at both the Prison and Probation Service and the police.

The Ombudsman visited eight local prisons in order to investigate how new remand prisoners are received in the Prison and Probation Service, including how they are informed of their rights and the framework for their stay in the local prison.

As part of the ivestigation, the Ombudsman also visited eight police districts in order to uncover how the police ensure that persons arrested by the police know their rights, for instance the right to contact relatives and legal counsel.

During the visits to both local prisons and police districts, there was also focus on how authorities retrieve and exchange information relevant to the remand prisoners' health and safety.

2. The investigation's main results

It is *the Ombudsman's overall assessment* that the Prison and Probation Service and the police generally take care to inform arrestees and new remand prisoners of their rights etc. and to ensure their safety.

Overall, both management and staff with the investigated authorities showed an understanding of and insight into the vulnerable situation that new remand prisoners can find themselves in.

With respect to the *Prison and Probation Service*, the investigation gives occasion for a few general recommendations.

As such, in several instances, there was a need to increase and maintain the focus on the requirements of the local prisons when they receive new inmates, including remand prisoners.

The Ombudsman generally recommends that the Prison and Probation Service ensure continued focus on new inmates receiving sufficient guidance about their rights etc. in connection with the reception in the local prisons.

The investigation also showed that prison officers to a great extent uncover new inmates' mental health conditions without having received prior guidance about this task and without supervision.

The Ombudsman generally recommends that the Prison and Probation Service ensure that staff receive guidance or training in uncovering mental health conditions, including suicidal thoughts, when receiving new inmates.

In addition, the investigation has resulted in some specific recommendations and focus points for the visited local prisons.

With respect to *the police*, the investigation resulted in a few specific recommendations and focus points for some of the visited police districts. They primarily concern the police's documentation of the guidance given to arrestees.

Furthermore, the investigation has shown some *issues of a more general nature*, which have not given occasion for recommendations etc. in relation to the visited local prisons or police districts. For example, in several police districts, the Ombudsman found that the police are sometimes unable to transfer an arrestee to a local prison due to the occupancy situation in the Prison and Probation Service. The arrestee must therefore spend the night in a detention cell at the police station – even though it is not designed for it – until a preliminary examination the next day has clarified whether the arrestee's deprivation of liberty is to continue. In that connection, the investigation has also shown that issues with ensuring correct guidance of the arrestee can arise.

The Ombudsman has planned meetings with the Department of Prisons and Probation and with the Danish National Police as the authorities responsible for, respectively, Danish local prisons and police districts. At these meetings, the Ombudsman will convey the knowledge and discuss the issues that were uncovered by the investigation of the practice in the local prisons and police districts.

In addition, there will be a follow-up on recommendations and other relevant matters during future monitoring visits.

The investigated conditions and the results of the investigation are described in further detail below under items 4 and 5.

3. Background and method

3.1. Background of the investigation

New remand prisoners in Prison and Probation Service institutions will often experience a significant change in their lives and may be in an uncertain and particularly vulnerable situation.

After agreement with the Prison and Probation Service, the Ombudsman receives reports on all deaths, suicides, qualified suicide attempts and other qualified self-harming acts among inmates in the custody of the Prison and Probation Service. These cases indicate that the risk of such serious incidents is increased in the first few days after arrest and placement in remand custody.

In addition, Denmark has several times been given recommendations from the European Committee for the Prevention of Torture (CPT) about, among other things, the police's safeguarding of arrestees' rights, most recently in connection with a visit that the CPT made in Denmark in 2019.

In 2015, the Prison and Probation Service implemented a new reception procedure in Danish prisons focusing on, for instance, guidance of new inmates and quick uncovering of urgent matters and issues, including mental challenges. The reception procedure is also followed by the local prisons in an adapted form.

At the same time, conditions in the Prison and Probation Service are currently affected by high occupancy levels in the institutions combined with staff shortage and recruitment issues.

Using these matters as a starting point, the Ombudsman has with the theme for 2022 wanted to investigate conditions for new remand prisoners with a focus on authorities' securing of the prisoners' safety and guidance about rights etc.

3.2. Investigation method

The theme was investigated through eight double monitoring visits – first a visit to a local prison and in continuation thereof a visit to the police district from which the local prison especially receives remand prisoners. In this way, the information collected by the visiting team in the local prison could be used at the subsequent visit to the police.

In connection with visits to the police districts, the visiting team also inspected detention cells and holding cells. Matters uncovered during this inspection are included in the report to the extent that they are relevant to the theme.

Before each visit, the Ombudsman asked the local prison's management to send some information and material to elucidate how the local prison organises the reception of new inmates, including any internal guidelines relevant to the local prison's reception procedure. In the same way, the relevant police district management was asked to send information and material about guidance of arrestees and transfer of remand prisoners to the Prison and Probation Service, for instance relevant action cards.

In addition, the Ombudsman asked the local prison and the police to send case documents concerning five remand prisoners that had recently been transferred from the police district to the local prison. The local prison was also asked to send health records of the five prisoners' first days in the local prison.

During the monitoring visits, the visiting teams spoke with management, staff, arrestees, inmates and possibly volunteer visitors (in local prisons) about conditions relevant to the theme.

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 that persons who are or who can be deprived of their liberty are exposed to for instance inhuman or degrading treatment, cf. the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

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 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. In Prison and Probation Service custody

4.1. Rules etc.

Remand prisoners' conditions are first and foremost regulated in the Executive Order on Remand Custody (Executive Order No. 173 of 31

January 2022) and in the guidance notes to the Executive Order (Guidance Notes No. 9074 of 31 January 2022 (Remand Guidance Notes)).

It is set out in the Executive Order on Remand Custody that remand prisoners must soon after arrival at an institution be informed of their rights, duties and other matters during the stay.

In addition, it is set out in the Executive Order on Remand Custody that a remand prisoner is entitled to medical treatment, including the summoning of their own doctor, and other health-related assistance pursuant to the rules in the Executive Order on Health-Related Assistance for Inmates in Prison and Probation Service Institutions (Executive Order No. 965 of 22 June 2022).

According to the latter Executive Order, the Prison and Probation Service Area must, as soon as possible after imprisonment, give the inmate general information about the healthcare scheme in the institution and must verbally offer the inmate a consultation with a doctor or nurse affiliated with the Prison and Probation Service Area. However, this does not apply if the stay is expected to be quite brief, or if the inmate has been transferred from another Prison and Probation Service institution where the inmate has been offered a consultation with a doctor or a nurse.

The Department of Prisons and Probation has issued a circular on creation of action plans in the Prison and Probation Service (Circular No. 9741 of 28 June 2022; the Action Plan Circular) and a guide on creation of action plans in the Prison and Probation Service (the Action Plan Guide; Guide No. 9926 of 26 August 2022). It is set out therein that action plans must be created for remand prisoners and that the first action plan must be created no later than seven working days after imprisonment. The Prison and Probation Service's action plans must be created in cooperation with the inmate.

4.2. The investigated conditions

As mentioned above under item 3.1, the Prison and Probation Service has implemented a procedure for receiving new inmates. The reception procedure was implemented in Danish prisons in 2015 and subsequently adjusted to the conditions in the local prisons.

The procedure presupposes that the local prisons go through the following three steps:

1. Reception interview

2. Uncovering mental health conditions

3. Establishing cooperation with authorities (action plan).

In the light of the relevant rules and guidelines, the Ombudsman's visiting teams investigated if – and how – the reception procedure had been implemented in the visited local prisons and how the local prison would otherwise inform new inmates of their rights etc.

In addition, the Ombudsman's visiting teams investigated the local prisons' practice in relation to informing new inmates about the local prison's healthcare services and other health-related matters of relevance to new inmates, especially including new remand prisoners.

The Ombudsman's visiting teams also focused on whether the local prisons use interpreters to a relevant extent when receiving foreign nationals.

Lastly, the Ombudsman investigated how the local prisons obtain relevant information from the police on transfer of new remand prisoners. The result of this part of the investigation can be found under item 5.4 below on the police transfer of arrestees to the Prison and Probation Service.

4.3. Reception interview and guidance about rights etc.

4.3.1. Basis of the investigation
As mentioned, it is set out in the Executive Order on Remand Custody and in the related Guidance Notes that, soon after arrival to a Prison and Probation Service institution, remand prisoners must be informed of their rights, duties and other matters during the stay.

According to the Prison and Probation Service's reception procedure, a reception interview must be held within the first 24 hours after imprisonment. The purpose of the reception interview is to uncover whether the inmate has urgent problems that must be taken care of immediately after imprisonment, for instance in relation to children, house pets, work, education, health or substance abuse etc. In connection with the interview, the inmate's apparent mental state is also uncovered; read more about this under item 4.4 below. A safety assessment is also made, which may include affiliation with certain groups and gangs as well as matters from any previous imprisonments.

Central information from the reception interview must be entered into a special module in the Prison and Probation Service's client system in order to ensure that the interview more systematically covers all relevant matters.

The Department of Prisons and Probation has made a leaflet, 'Information about arrest and remand custody', with guidance about the legal situation that arrestees and remand prisoners are in and with guidance about for

instance the possibility of receiving visits and contacting relatives, legal counsel and authorities etc.

The leaflet has been translated into 16 languages and must be handed out to inmates upon imprisonment, according to the Remand Guidance Notes. In relation to the Prison and Probation Service's reception procedure, a standard checklist has been created, which says that the leaflet is to be handed out to the new inmate in a relevant language.

During the monitoring visits, particularly staff in the local prisons have pointed out that new remand prisoners focus a great deal on their situation and on urgent matters that must be taken care of. On arrival, the prisoners can thus be less receptive to guidance about rights etc. during imprisonment.

During the investivation, the Ombudsman's visiting teams have therefore focused on whether the local prisons' staff, to a relevant extent, take care to follow up on the reception interview and the written guidance about the inmates' rights etc., including how the staff ensure that the inmates have the necessary information, if the inmates are encouraged to ask questions, etc.

The Remand Guidance Notes further presuppose that a short and easy-to-read written briefing on the institution will be handed out when receiving the remand prisoner. In that connection, the Ombudsman's visiting teams investigated whether new inmates receive guidance about and are made familiar with the local prison's house rules etc. in order to acquaint themselves with relevant matters as well as rights and duties in the local prison.

Lastly, the Ombudsman's visiting teams investigated whether the local prisons ensure that prisoners with linguistic challenges, including foreign nationals, understand the guidance given upon reception.

4.3.2. Results of the investigation

The investigation has shown that it is an incorporated practice with the local prisons that a prison officer has a reception interview with the inmate within the first 24 hours after imprisonment.

Generally, the local prison staff focus on guiding new inmates, including remand prisoners, on an ongoing basis about their possibilities of using their rights and about conditions in the local prison. At the same time, the staff support the inmates' use of their rights, for instance by helping the inmates contact employer and relatives, including facilitating visits. Generally, the staff also take care to help new inmates with using in practice the possibilities in the local prison in order to have a sense of community with other inmates, to exercise, etc.

In some instances, however, it was found in connection with some interviews with inmates that the inmates had had to be proactive in order to get information about their rights etc., including that the inmates had had to seek information about the conditions in the local prison by asking other inmates.

In three local prisons, management was recommended to ensure continued focus on inmates receiving sufficient guidance about their rights etc. upon reception.

It was the visiting teams' impression that new inmates were generally receiving clear guidance about the most important conditions in the local prisons. A central part of this is that new inmates are made familiar with the local prison's house rules, to begin with typically in the form of a more brief and easy-to-read overview (a 'pixie' version of the house rules or similar).

In relation to two local prisons, the Ombudsman has given recommendations to ensure that inmates are made familiar with the local prison's house rules upon reception and that the house rules are available to all inmates.

It was recommended to three local prisons that the house rules, including the short overview version, be translated into relevant languages.

Based on the investigation, it is also the visiting teams' impression that the local prisons focus on relieving language barriers and to a great extent use interpreters when needed.

However, in relation to three visits, the Ombudsman has recommended that the local prison ensure use of interpreters to the necessary extent, including during reception interviews.

The conditions found during the investigation of the local prisons' guidance of new inmates have overall led the Ombudsman to generally recommend that the Prison and Probation Service ensure continued focus on new inmates receiving sufficient guidance about their rights etc. in connection with reception.

4.4. Uncovering mental health conditions

As part of the Prison and Probation Service's reception procedure, the local prisons must within the first 24 hours after imprisonment uncover new inmates' mental health conditions.

The uncovering is typically conducted by a prison officer in connection with the reception interview, as described above. It presupposes that the prison

officer ask questions about the inmate's previous contact with the psychiatric sector and about any thoughts of suicide or self-harm.

With the exception of Western Prison (Vestre Fængsel), which is the largest local prison in Denmark, the investigation showed that prison officers carried out this task without further prior guidance and to a great extent without supervision.

In relation to two local prisons, the Ombudsman has therefore recommended that staff receive guidance or training in uncovering mental health conditions, including suicidal thoughts, when receiving new inmates. In relation to another five local prisons, this has been emphasised during discussions with the local prison management as a matter that the local prison should focus on.

The Ombudsman generally recommends that the Prison and Probation Service ensure that staff receive guidance or training in uncovering mental health conditions, including suicidal thoughts, when receiving new inmates.

4.5. Establishing cooperation with authorities (action plan)

As mentioned above under item 4.1, according to the Action Plan Circular, an action plan must be created for inmates within seven working days after imprisonment in the local prison. In accordance with this, it is set out in the Prison and Probation Service's reception procedure that the inmate's needs must be uncovered within seven working days.

According to the Prison and Probation Service's reception procedure, a cooperation must be established between the relevant authorities within 10 working days after imprisonment. Generally, this is done by a caseworker in the local prison telephoning the relevant municipality.

Overall, the investigation showed that the local prisons' practice in this area works well and is in accordance with relevant rules and guidelines.

The conditions thus only gave occasion for a few specific recommendations. The Ombudsman recommended that one local prison ensure that the deadlines for creating action plans be observed. In two local prisons, there were questions about the inmates' knowledge of the contents of their action plans, including in instances where the action plan was not handed out to the inmate. It was recommended to those two local prisons that they consider how to ensure that the inmate is familiar with the action plan.

4.6. Health-related matters upon reception of new inmates

4.6.1. New inmates' contact with healthcare staff
The visited local prisons all had a scheme that meant that new inmates were offered a check-up by a nurse within the first few days after imprisonment. In that connection, the inmates received a general briefing on the healthcare services in the local prison.

The local prisons' practice was thus in accordance with the rules that, soon after imprisonment, new inmates must receive a general briefing on the healthcare scheme and be offered a consultation with a doctor or a nurse affiliated with the Prison and Probation Service.

In addition to the written records about five new inmates that the Ombudsman had asked for as part of the investigation, the visited local prisons were also asked to register how many new inmates that had been referred to the local prison's doctor or for external medical treatment within a given period. The registered information showed that new inmates were referred to a doctor or specialist etc. to a certain extent. The information has not given the Ombudsman occasion for comments or to conduct further investigation.

During the investigation, the Ombudsman's visiting teams also focused on the extent to which the healthcare services used interpreters and if they instead used for instance Google Translate or included other inmates as 'interpreters' in connection with the uncovering of health conditions.

Generally, it is the visiting teams' understanding that the healthcare services when in contact with new inmates, including remand prisoners, use interpreters to a relevant extent and that other initiatives of the mentioned nature in the healthcare services only take place on a very exceptional basis and in quite rare situations.

In addition, it is the visiting teams' general assessment that the healthcare staff and the uniformed staff focus on, to the necessary extent, exchanging information that is relevant to the new inmates' health and safety, including information about new inmates' mental health conditions uncovered during the reception interview (item 4.4 above).

The investigation of health-related matters when receiving new inmates has overall not given the Ombudsman occasion to give recommendations etc. relating to the theme of the investigation. However, the Ombudsman has recommended that two of the visited local prisons ensure that the health-related documentation meets the formal requirements for record-keeping.

4.6.2. Documentation upon suspicion of abuse
In connection with visits to two local prisons, the Ombudsman's visiting teams received information and material about two incidents where information had arisen about possible abuse by the police in connection with the arrest before the inmate was placed in the local prison.

The information and documentation in the two cases led the visiting teams to investigate the Prison and Probation Service's – including especially the healthcare services' – documentation in several local prisons as well as their securing of medical traces and evidence if information arose about possible abuse of a person while in police or Prison and Probation Service custody.

The local prisons' information indicates that there is no fixed practice, procedure or the like for how the local prisons' healthcare services handle such matters. The issue will be part of the discussions of relevant general matters with the Department of Prisons and Probation as a follow-up on the monitoring visits.

5. In police custody

5.1. Rules etc.
The Ministry of Justice has issued a circular (Circular No. 9155 of 18 March 2010) for the police and the Prosecution Service about arrestees' right to notify relatives etc., contact with legal counsel and national representation as well as access to a doctor.

The circular contains guidelines for the police's guidance of arrestees about their rights; read more under item 5.2.1 below about the basis of the investigation of police practice. For arrestees who are charged by the police, the circular's rules on contact with legal counsel supplements Executive Order No. 467 of 26 September 1978 on Guidance for Charged Arrestees on Access to Request Defence Counsel.

In addition, the Danish National Police has created action cards on filling in prisoner information sheets for remand prisoner cases that describe how the individual items in the sheets are to be used. The prisoner information sheets are pre-printed forms, which the police and the Prosecution Service fill in digitally or manually and which contain central information about the arrestee, including information relevant to the police investigation and the inmate's and the staff's safety. The prisoner information sheets follow the arrestees in connection with appearance in court and the transfer to the Prison and Probation Service. The Danish National Police's action cards and the police districts' local guidelines and action cards have been retrieved and to the relevant extent included in the basis of the investigation.

5.2. Guidance to the arrestee

5.2.1. Basis of the investigation
It is set out in the above-mentioned circular from the Ministry of Justice that the police must inform arrestees of the following:

- Arrestees' access to notify relatives etc. about the arrest
- Arrestees' access to contact legal counsel
- Arrestees' access to medical attention if needed.

Foreign national citizens must also be informed of the access to contact their country's embassy or consulate. The guidelines also state that the guidance must take place in a language that the arrestee understands.

During the monitoring visits to the eight police districts, it was investigated whether the police observe this guidance duty and how the police support the arrestees in using their rights.

5.2.2. Result of the investigation
The Danish National Police has created a leaflet that includes guidance about the matters mentioned in bullets above and on the possibilities of complaining about the police. The leaflet is available in 12 languages.

The visiting teams' conversations with management as well as staff showed that the police hand out the leaflet to all arrestees as part of a fixed routine. The visiting teams found that there were usually versions of the leaflet in different languages lying by the reception desk at the police stations (where all arrestees are brought in).

According to the police's information, the police use interpreters as needed, either in the form of telephone interpreting or by the interpreter showing up in person. Interpreting often takes place early on, in some cases already in the patrol car after arrest.

Furthermore, it is the visiting teams' general understanding that the police also take other measures to make the guidance understandable to all arrestees, including by repeating the written guidance verbally and by encouraging the arrestees to ask questions.

The visiting teams' understanding of the police's handling of this task was verified by statements from inmates in the local prisons who had recently been in police custody.

The documents in the specific cases about arrestees that the Ombudsman had received before the monitoring visit and supplementary explanations from police management and staff showed that the police's reports are to a great extent filled in using fixed templates. This also applies to the police's guidance of arrestees. As such, the police's case management system works as a kind of checklist for police staff in order to document relevant matters. However, the case management system does allow for adaptations and additions based on specific matters in the cases, of which the visiting teams saw many examples.

The visiting teams found differences in the police districts' use of the case management system to document the guidance of arrestees. In some police districts, the guidance was primarily documented through physical documents and not in the electronic case management system.

In a few police districts, there were instances where the guidance had not been documented in the case material at all. The Ombudsman recommended that one police district ensure that it was documented that arrestees have received guidance about their rights, while it was emphasised to two police districts as a matter that they should focus on.

Only in one police district, the Ombudsman's visiting teams could doubt whether the police in all instances took care to ensure sufficient guidance of the arrestees about their rights, especially with respect to repeat offenders who had previously been arrested. In some of the reviewed cases from the same police district, documentation of the guidance was missing. In that case, the Ombudsman recommended to ensure that arrestees be informed of their rights etc. and that this is documented.

5.3. Health-related matters

Based on the investigation, it is the Ombudsman's assessment that the police generally ensure the requisition of timely medical assistance from a doctor for arrestees complaining about or presenting symptoms of illness that may require urgent medical attention.

5.4. Police transfer of arrestees to the Prison and Probation Service

It is the visiting teams' impression that, overall, there is good cooperation between the police and the Prison and Probation Service with respect to new remand prisoners' conditions.

As mentioned under item 5.1 above, the Danish National Police has created prisoner information sheets that are to follow the arrestees when they are transferred to other authorities. One of these prisoner information sheets is designed to follow arrestees who are to be brought for preliminary

examination and who can be remanded in custody of the Prison and Probation Service.

Under 'Information about special conditions' in the prisoner information sheet, it is stated in parentheses that the police must fill in information about 'illness, suicide risk, etc.' The purpose is that such central information is noted clearly for authorities receiving the arrestee, including the Prison and Probation Service or possibly the psychiatric sector.

The monitoring visits have generally shown that the police fill in the prisoner information sheets and that the local prisons through prisoner information sheets and verbal information from the police are given the necessary information about arrestees, including in order to attend to new remand prisoners' safety.

In a few instances, the visiting teams could point to health-related matters or knowledge about suicide risk which were evident from the cases that the visiting team had reviewed before the visit but which did not appear from the specific prisoner information sheets in the cases. The investigated matters have not led to recommendations, but it has been pointed out to two police districts that the police should take care to ensure that all relevant information follows an arrestee on transfer to the Prison and Probation Service. Actual recommendations were not given to the specific police districts, among other things because measures had already been initiated in order to ensure that such information was noted on the prisoner information sheet and because, based on information from the police and the relevant local prison, the visiting teams could assume that information of this nature was forwarded verbally to the receiving authority.

5.5. Placement of arrestees in detention cells and holding cells

5.5.1. Rules

With authority in the Police Act, there are rules on placement in detention cells in the Executive Order on Detention (Executive Order No. 988 of 6 October 2004) and in the Detention Proclamation (the National Commissioner of Police's Proclamation A II No. 55 of 2 February 2006 on placement of intoxicated persons in police detention cells).

However, the rules in the Executive Order on Detention do not apply if, as an exception, the detention cell is used for placement of non-intoxicated persons. In a circular letter of 12 January 2011, the Danish National Police has stated guidelines for the police's use of detention cells and holding cells for placement of arrestees.

5.5.2. Placement in a holding cell
An arrestee is placed in a holding cell at the police station for periods when the arrestee for instance is waiting for questioning and appearance in court or possibly afterwards waiting for transfer to remand custody.

The Danish National Police's guidelines presuppose that arrestees are only placed in holding cells for brief periods of time. The information that the visiting teams received from the police confirmed that this is the case.

The inspection of holding cells at the eight visited police stations did not give occasion for initiatives of general importance to the investigation's theme about the conditions for arrestees and possible later remand prisoners.

5.5.3. Placement in a detention cell
Generally, only people who are under the influence of alcohol or euphoriant drugs etc. are placed in a detention cell – and only if they are a danger to themselves or others, or if deemed necessary in order to uphold public order and safety.

Arrestees who are to be questioned and possibly appear in court are instead placed in a holding cell. When staying longer, including overnight, arrestees are usually placed in a local prison.

However, arrestees who are under the influence of alcohol or euphoriant drugs etc. when arrested can initially be placed in a detention cell and later be moved to a holding cell awaiting questioning or appearance in court etc.

There is no bed in a detention cell, so if spending the night, the arrestee has to sleep with a blanket on a mattress on the floor. In addition, there is a risk of being disturbed because new arrestees or detained intoxicated people may be brought into detention during the night.

Only in exceptional cases are detention cells meant to be used for people who are not intoxicated. As such, they are not designed for arrestees spending the night. However, the visiting teams found in several police districts that it happened regularly that arrestees who were not intoxicated spent the night in a detention cell because the local prisons did not have capacity to receive the arrestee due to overcrowding.

In that connection, the visiting teams also found that the mentioned issue sometimes meant that arrestees who had been placed in a detention cell because there was no room in a local prison were given the leaflet 'Where do you go when you go out', even though it contains information that is only relevant to detained intoxicated people etc. Conversely, the visiting teams

found that detained intoxicated people etc. in some instances were given the Danish National Police's leaflet, the purpose of which is to guide arrestees.

The use of detention cells for arrestees spending the night and the issue of ensuring correct guidance will, as mentioned above under item 2, be discussed at meetings with the responsible authorities in the police and the Prison and Probation Service.

The conditions in detention cells gave no occasion for other measures towards the visited police districts.

Sincerely,

Niels Fenger

Thematic report 2022: Small private accommodation facilities for young people

Contents

1. Introduction

Small private accommodation facilities for young people was the theme of those monitoring visits (within the theme) that the Ombudsman carried out in the children's sector in 2022 in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

In order to elucidate the theme, the Ombudsman carried out a total of eight monitoring visits to accommodation facilities with generally eight to ten places for young people aged 13-17 years. One visit was carried out virtually due to COVID-19, while the other visits were carried out physically. The monitoring visits focused especially on:

- Use of physical force and search of person and room
- Return of runaways and detaining in connection with or during placement
- Drug testing
- Prevention and handling of alcohol and drug abuse, sexual abuse and self-harming behaviour
- Healthcare services.

2. What have the thematic visits shown?

2.1. Main conclusions

- The visited accommodation facilities used physical force and other restrictions of the right to self-determination to a limited extent, and the monitoring visits left the overall impression that the facilities were focused on handling conflicts in a pedagogical, constructive and dialogue-based way.

- Staff in several of the accommodation facilities had only a more general knowledge of the rules under the Act on Adult Responsibility for Children and Young People in Out-of-Home Care on, among other things, physical force, including on how physical force should be carried out in practice.

- The deadline for recording and reporting use of physical force and search of person and room was in several instances not observed, and the report forms often did not contain an adequate description of the course of events in connection with use of force.

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

- The monitoring visits left the overall impression that the accommodation facilities were focused to a relevant extent on prevention and handling of alcohol and drug abuse, sexual abuse and self-harming behaviour.

2.2. General recommendations

On the basis of the monitoring visits, the Ombudsman generally recommends that private accommodation facilities

- ensure that the deadline is observed for recording use of physical force and search of person and room and for reporting to and informing the relevant authorities and custodial parents.

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

- ensure that report forms on search of person and room contain an adequate description of the course of events, including a specification of whether or not the child or young person has been informed of the reason for the search and has been asked to hand over any effects voluntarily.

- ensure that staff are sufficiently familiar with the rules under the Act on Adult Responsibility for Children and Young People in Out-of-Home Care, including the rules on the use of physical force, and that the accommodation facilities 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 are informed of their rights in relation to the use of force and other restrictions of the right to self-determination, including complaint access. In this context, the Ombudsman recommends that facilities consider drawing up written material on rights and complaint access that can be handed out on arrival

- ensure that drug tests are used in accordance with the relevant rules, including that general consent for the use of drug tests is obtained, either in connection with arrival or during the placement period if the need for being able to use a drug test arises, and that the placing municipality and custodial parents are informed that a drug test has been used and of the result of the test.

- ensure that medicines management is carried out in accordance with applicable rules and that instructions on medicines management are drawn up in accordance with the Danish Health Authority's national clinical guidelines on drawing up instructions.

The Ombudsman will discuss the follow-up on the general recommendations with, respectively, the Ministry of Social Affairs, Housing and Senior Citizens and the Ministry of the Interior and Health. The Ombudsman will also follow up on the general recommendations during future monitoring visits.

On the basis of the monitoring visits, the Ombudsman has raised an own-initiative case on the application of drug tests. Read more below in item 6.2.

2.3. Background for the choice of theme and focus area

A number of conditions for children and young people placed outside the home are regulated in the Act on Adult Responsibility for Children and Young People in Out-of-Home Care (Consolidation Act No. 764 of 1 August 2019) and the appurtenant Executive Order and Guideline. These conditions include staff's access to using force and carrying out other restrictions of the right to self-determination of children and young people. In the interests of the legal rights of the children and young people, it is important that staff are familiar with these rules.

On that background, the Ombudsman wanted to examine conditions in small private accommodation facilities in order to uncover whether their staff are sufficiently familiar with the rules of the Act on Adult Responsibility concerning the subjects that the visits were focused on, cf. item 1 above.

The Ombudsman primarily visited facilities where the target group is young people with, among others, alcohol or drug abuse, self-harming behaviour and the like.

The aim of visiting accommodation facilities with this target group was to gain knowledge of how the facilities handle the young people's challenges and what type of addiction treatment the young people can access.

In this connection, among others the Act on Adult Responsibility's rules on search of person and room, return of runaways, detaining in connection with or during placement and drug testing may be relevant. In connection with the monitoring visits, the Ombudsman therefore wanted to examine whether the facilities are familiar with these rules and to what extent the facilities make use of the possibilities the rules afford.

Young people with an alcohol or drug abuse who are placed outside the home could potentially be vulnerable to exploitation of a sexual nature, among other things. The Ombudsman therefore wanted to examine whether the facilities have knowledge of, and guidelines for, prevention and handling of sexual abuse. In relation to young people with self-harming behaviour, the Ombudsman also wanted to examine whether the facilities have knowledge, including guidelines, regarding prevention and handling of self-harming behaviour.

Lastly, the Ombudsman wanted to shed light on the young people's access to healthcare and the medicines management of the visited facilities.

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 accommodation facilities' 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 other things, the chosen focus areas.

Immediately prior to the monitoring visit, the Ombudsman informed the young people of the visit with a view to speaking with as many young people as possible. During the monitoring visits, the visiting teams spoke with a total of 41 young people aged 13-17 years.

Furthermore, the visiting teams spoke with the parents of the young people (a total of 33 parents). In addition, the visiting teams spoke with the accommodation facilities' staff, including those responsible for medicines, and the visiting teams also obtained information about the facilities 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 may 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 human rights and medical 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, among others, the UN Convention on the Rights of the Child.

Generally, the Ombudsman's Special Advisor on Children's Issues participates in monitoring visits in the children's sector.

2.4.3. List of visits in 2022
On the Ombudsman' website, there is a summary of all monitoring visits in 2022, including the recommendations given to the individual accommodation facilities: Completed visits in the children's sector in 2022 (ombudsmanden.dk)

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 accommodation facilities can use physical force against a child or young person when certain conditions are met.

However, use of physical force must only be used as an exception. And use of physical force must never take the place of care and socio-pedagogical measures. In addition, use of physical force must always be in reasonable proportion to the aim and must be exercised as gently and briefly as circumstances allow, and with the greatest possible regard for the personal integrity of the child or young person. This follows from the general principles for 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 young person to another room.

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

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

The child or the 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 facility, 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 complaint access.

3.2. Extent of the use of physical force

The visits generally left the impression that the accommodation facilities only use physical force towards the young people to a limited extent and that the facilities seek as much as possible to avoid using physical force and other restrictions of the right to self-determination.

The visited facilities explained to a relevant extent how they via pedagogical measures were focused on preventing use of force and other restrictions of the right to self-determination through, among other things, dialogue, de-escalating behaviour and Low Arousal. Most of the accommodation facilities also stated that they to a certain extent have access to external supervision in the form of for instance psychological assistance in relation to the work with the young people.

Prior to the visits, the Ombudsman obtained information about, among other things, the number of physical force episodes in the period 2019-2021. The received information shows that the individual accommodation facilities had a total of between 0 and up to 10 recorded physical force episodes towards young people under the age of 18 in this period.

3.3. Examples of reports

The accommodation facilities 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 (Executive Order No. 810 of 13 August 2019 on Adult Responsibility for Children and Young People in Out-of-Home Care).

In connection with the monitoring visits, the Ombudsman obtained the most recent report forms concerning use of physical force from the seven facilities that had reported use of physical force in the period in question. The Ombudsman received a total of 28 report forms.

The review of the reports formed a basis for discussions between the visiting teams and the visited facilities during the monitoring visits.

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, pursuant to the rules on adult responsibility the accommodation facility's manager (or the deputy manager) must put the episode on record within 24 hours. The short deadline is primarily out of regard for the legal rights of the children and young people, but also out of regard for the staff involved in the episode.

Then the manager (or the deputy manager) of the accommodation facility must without undue delay – meaning as quickly as possible within 24 hours once the recording has been completed – send a copy of the report 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 supervision authority, and a municipal or regional operator, if any, must be informed.

Review of the received report forms showed that none of the seven accommodation facilities reporting use of physical force had fully observed the deadlines for recording and reporting the use thereof. One of the facilities, however, had only exceeded the deadline for reporting to the placing municipality in a single instance. In another facility, the failure to meet the deadline primarily concerned a single episode where the facility was in doubt about the duty to report. In addition, the background for exceeding the deadline in one of the other facilities was that the former practice had been to await the young person's comments about the report, but the facility had changed its practice when informed by the local social supervision authority that it is possible to send in the young person's comments afterwards.

Several of the reports did not contain any information on the custodial parents having been informed of a physical force episode.

On that background, the Ombudsman recommended four accommodation facilities to ensure that the deadlines for recording and reporting use of physical force be observed.

One of the facilities was at the same time recommended to ensure that all the facility's force episodes be recorded and reported.

On that basis, the Ombudsman generally recommends that the accommodation facilities ensure observance of the deadlines for recording a physical force episode and the deadlines for reporting to and informing the relevant authorities and custodial parents.

The Ombudsman has previously raised the question of how to understand the deadline for reporting to the local social supervision authority ('by the end of the month') with the, then, Ministry of Social Affairs and Senior Citizens (now the Ministry of Social Affairs, Housing and Senior Citizens). In a letter of November 2022 to the five social supervision authorities, the Ministry has stated that the deadline for reporting to the local social supervision authority 'by the end of the month' applies to the transition from one calendar month to another and that copies of the report forms for a current calendar month must thus be sent in at the end of that month (and not within a period of 31 days).

3.3.2. Documentation for 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 force episode and a precise account of how the child or the 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 of the Act on Adult Responsibility.

Some of the report forms that the Ombudsman received did not contain an adequate description of the course of events or of how the use of force was carried out, for instance how the child or young person had been conducted or manually restrained. Furthermore, many reports lacked other information, including information on inclusion of the young person, cf. read below in item 3.3.3.

On that background, the Ombudsman recommended to the seven accommodation facilities that had reported use of physical force that they ensure adequate completion of the report forms.

The Ombudsman generally recommends that it is ensured that report forms on the use of physical force contain an adequate description of the course of

events, including a description of how specifically the child or young person was conducted or manually restrained, together with grounds for the necessity of the intervention.

3.3.3. Inclusion of the young person
Children and young people who have been involved in a physical force episode 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 adult responsibility legislation.

The visits left the general impression that after use of force, the accommodation facilities spoke with the young people both about the episode and about the fact that it had been put on record and the contents thereof.

However, the Ombudsman did recommend to one facility to ensure that after use of physical force the young people be informed that the episode has been put on record and the contents thereof and be given the opportunity to comment on the episode. It was pointed out to another facility that its staff were not sufficiently mindful that after a force episode – and in addition to being given the opportunity to comment on the episode – the young person must also be informed that the episode has been put on record and the contents thereof.

Review of the actual report forms on use of physical force also showed that in most cases, the young person had had the opportunity to comment on the episode, but for several facilities, it did not appear clearly from the report form whether the young person had been made aware that the episode had been put on record and been informed of the contents of the report. As mentioned above in item 3.3.2, the Ombudsman recommended to seven accommodation facilities that the report forms be adequately completed.

3.4. Knowledge of rules etc.
Children and young people placed in accommodation facilities 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 use of physical force towards the children and 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.

All the visited accommodation facilities had written guidelines on the use of physical force. During the monitoring visits, the visiting team received the general impression that staff were very reluctant to use force but also that staff in several of the facilities only had a mere general knowledge of the rules of the Act on Adult Responsibility, including how physical force ought to be carried out in practice in relation to for instance the use of gentle restraining holds.

Several of the facilities had young people in after-care, but staff were not aware that the rules on use of physical force in the Act on Adult Responsibility do not apply to young people in after-care.

Management in several of the accommodation facilities indicated that the limited knowledge of the rules is probably because physical force is seldom used. In this connection, the visiting teams stated that staff should have an adequate knowledge of the rules in any event, including the rules on what restraining holds to use if the need therefore arises. In addition, there were during several of the monitoring visits general discussions regarding the boundaries between care and force.

The Ombudsman gave five accommodation facilities a recommendation aimed at ensuring that staff had an adequate knowledge of the rules of adult responsibility legislation on, among other things, the use of physical force, including on how physical force should be used in practice.

At the same time, the Ombudsman recommended four accommodation facilities to ensure that the internal guidelines on the use of physical force are in accordance with and describe the central requirements of adult responsibility legislation.

In the light thereof, the Ombudsman generally recommends that the accommodation facilities ensure that staff have an adequate knowledge of the rules of adult responsibility legislation, including on the use of physical force, and that the facilities have written guidelines on the use of physical force and other restrictions of the right to self-determination.

3.5. Information on rights

In connection with placement in an accommodation facility, the manager must inform the child or young person and the custodial parents of their rights in relation to the use of force and other restrictions of the right to self-determination, including the access to complain to the National Social

Appeals Board and the municipal council, respectively. This follows from adult responsibility legislation.

The visits showed that several accommodation facilities did not in connection with the placement inform the young people and the custodial parents of their rights in relation to the use of force etc.

The Ombudsman recommended five accommodation facilities to ensure that the young people and the custodial parents are informed on arrival of their rights in relation to the use of force and other restrictions of the right to self-determination, including access to complain to the National Social Appeals Board and the municipal council, respectively. One accommodation facility was given a recommendation aimed at ensuring that the information material was in accordance with the rules in the adult responsibility legislation.

On that background, the Ombudsman generally recommends that facilities ensure that, on arrival at the facility, children, young people and custodial parents are informed of their rights in relation to use of force and other restrictions of the right to self-determination, including complaint access. In this context, the Ombudsman recommends that facilities consider drawing up written material on rights and complaint access that can be handed out on arrival.

4. Search of person and room

4.1. The rules

It follows from the Act on Adult Responsibility that accommodation facilities can search a child or young person placed in the facility, or search their rooms, provided certain conditions are met. A search of person or room must be carried out in compliance with the general principles for the use of force, cf. item 3.1.

SEARCH OF PERSON AND ROOM

When
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.

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*, and the child or young person may be required to take off coat, headgear and shoes.

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 results*.

Documentation and hearing
The accommodation facility 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 reasons 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.

4.2. Extent of search of person and room

Prior to the visits, the Ombudsman obtained information about, among other things, the number of searches of persons and rooms in the period 2019-2021. It appears from the forwarded information that the accommodation facilities carry out searches of persons and rooms very rarely. According to the information, four of the visited facilities had not carried out any searches at all during the period, three facilities had carried out a single search, while the last facility had carried out four searches during the period. Out of a total of seven searches, only one was search of a person.

A few of the accommodation facilities stated that – out of consideration for the relationship with the young people – they always contact the police instead of conducting the search themselves if they suspect that a young person is in possession of something illegal. One of the other facilities stated that they had also made use of the police several times instead of carrying out a search themselves. Some facilities stated that they had never carried out and would never carry out a search of persons themselves.

Several of the accommodation facilities stated that the facility always encourages the young people to hand over any items that the young persons are not allowed to have, and that the young people usually hand over the items voluntarily.

4.3. Examples of reports

Search of person and room must be recorded on the same form – and the same deadlines apply to reporting etc. – as for use of physical force, cf. item 3.3.1 above.

The review of the individual reports formed the basis for discussions between the visiting teams and the relevant visited facilities during the monitoring visits.

4.3.1. Observance of deadlines for recording and reporting search of person and room

The review of the report forms showed that the deadlines for recording and reporting search of person and room were not observed in all instances.

The Ombudsman recommended two out of the four accommodation facilities that had carried out such searches to ensure that the deadlines for recording and reporting search of person and room be observed.

The Ombudsman generally recommends that the accommodation facilities ensure that the deadline for recording search of person and room and for reporting to and informing the relevant authorities and custodial parents be observed.

4.3.2. Documentation for search of person and room

The majority of the received report forms did not contain an adequate description of the course of events etc. in connection with the search. The reports did not show for instance whether the young person had been informed of the reason for the search, whether the young person had been encouraged to hand over the object(s) of the search voluntarily or how the search went. In addition, several reports lacked information about inclusion of the young person, cf. item 4.3.3 below.

The Ombudsman recommended all four accommodation facilities that had carried out such searches to ensure that the report forms be adequately filled in.

The Ombudsman generally recommends that the accommodation facilities ensure that the report forms contain an adequate description of the course of events in connection with the search, including an indication of whether the

child or young person has been informed of the reason for the search and has been encouraged to hand over any items voluntarily.

4.3.3. Inclusion of the young person
The review of the report forms on searches of persons and rooms showed that in most instances, the young person was given an opportunity to comment on the episode, but it did not appear clearly from the forms whether the young person was informed that the episode had been put on record and the contents thereof. As mentioned under item 4.3.2, the Ombudsman recommended all four accommodation facilities that had carried out searches to ensure that the report forms be adequately filled in.

4.4. Knowledge of the rules
During the monitoring visits, the visiting teams received the general impression that staff at the majority of the accommodation facilities had a general knowledge of the rules on search of person and room but also that some of the staff were uncertain about a few central elements in the provisions.

The majority of the accommodation facilities had internal guidelines on search of both person and room. In several instances, however, the guidelines were not adequate or clear in relation to central requirements in the underlying rules. Among other things, it was not clear in all guidelines who can decide that a search is to be carried out or that a list must be drawn up of confiscated items belonging to the young person, and that the list must be given to the young person. Furthermore, it did not appear in all guidelines that search of persons only as an exception can be carried out and witnessed by persons of a different gender to the young person.

The Ombudsman recommended one accommodation facility to ensure that all members of staff are familiar with the rules on room searches. The Ombudsman also gave three accommodation facilities recommendations with the aim of ensuring that their internal guidelines on search of person and room describe the central requirements in the applicable rules. One of the other accommodation facilities was recommended the same, solely with regard to the guidelines for room searches, and was also recommended to consider drawing up internal guidelines on search of persons. Another accommodation facility was recommended to consider drawing up written guidelines for room searches, describing the central legislative requirements.

As it appears above under item 3.4, the Ombudsman generally recommends accommodation facilities to ensure that staff are sufficiently familiar with the rules of the adult responsibility legislation, and that the facilities have written guidelines on the use of physical force and other restrictions of the right to self-determination. This includes the rules on search of person and room.

In connection with some of the monitoring visits, the visiting teams pointed out to the accommodation facilities that confiscation of items must be recorded on the report form, which has an individual box for it.

4.5. Information on rights

As appears above under item 3.5, the Ombudsman generally recommends that the accommodation facilities ensure that – in connection with the child or young person being placed in the facility – children, young people and custodial parents are informed of their rights in relation to the use of force and other restrictions of the right to self-determination, including complaint access. In this context, the Ombudsman recommends that the accommodation facilities consider drawing up written material on rights and complaint access that can be handed out on arrival.

5. Return of runaways and detaining in connection with or during placement

5.1. The rules

It follows from the Act on Adult Responsibility that when certain conditions have been met, accommodation facility staff can return a child or young person placed at the facility when the child or young person has run away. Furthermore, it can be decided that a child or young person placed in care can be detained at the accommodation facility in connection with or during placement. Return of runaways and detaining must be carried out in accordance with the general principles on use of force, cf. above under item 3.1.

RETURN OF RUNAWAYS AND DETAINING

Who and what

Return of runaways

As part of the duty of care, staff can return a runaway child or young person who has been placed at the facility. By *'return'* is meant that staff can manually restrain and conduct the child or young person back to the accommodation facility. By *'runaway'* is meant that the child or young person has left the accommodation facility with no intention of coming back.

Detaining

The Children and Young Persons Committee or the Juvenile Crime Board can decide that a child or young person placed in care can be detained at the accommodation facility for up to *14 days in connection with the*

placement. It can also be decided to detain the child or young person at the accommodation facility for up to *14 days during the placement*. Such a detention can remain in force for *another 14 days* under special circumstances.

Staff can – within the scope of the decision to detain – physically restrain the child or young person in order to prevent the child or young person from leaving the accommodation facility.

When
Return of runaways
Return of runaways can take place when the child or young person exhibits a behaviour that may result in *risk of harm for the child or the young person or for others*.

Detaining
Detaining can take place when it must be considered to be of decisive importance in order to meet a child's or young person's *special need for support*, and it is deemed to be of *decisive importance to the socio-pedagogical treatment*.

Documentation and hearing
The accommodation facility must *record and report* return of runaways and detaining.

The child or young person must be *informed that it has been put on record and the contents thereof*, and be given the *opportunity to comment*.

5.2. Extent of return of runaways

None of the visited accommodation facilities had carried out return of runaways within the last three years.

All visited facilities stated that they have or have had young people running away. However, the facilities do not return the young people by means of force but, on the contrary, use a pedagogical approach to the young people to make them return to the accommodation facility voluntarily. The accommodation facilities explained how they endeavour to establish a contact with a young person who has run away, for instance via telephone, text or social media. Several of the facilities also stated that if staff see a young person run away, they go after the young person with a view to persuading him or her to return voluntarily. The facilities stated that if they are worried about a young person who has run away, they will contact the police, and several facilities stated that if it becomes necessary to return the young

person by force, they will leave this task to the police in order not to damage the facility's relationship with the young person.

The majority of the accommodation facilities had internal guidelines on return of runaways, but it was the visiting teams' general impression that staff had a limited knowledge of the relevant rules. As mentioned under item 3.4, the Ombudsman generally recommends that the facilities ensure that staff are sufficiently familiar with the rules of the Act on Adult Responsibility. These include the rules on return of runaways.

The Ombudsman gave one accommodation facility a recommendation to ensure that the internal guidelines on the return of runaways describe the central requirements in the applicable rules.

5.3. Extent of detaining in connection with or during a placement

Several of the visited accommodation facilities had had one or a few young people where a decision had been made to detain them. However, none of the facilities had needed to prevent the young people from leaving the facility. A few of the visited facilities told the visiting teams that they would refuse or consider to refuse to receive a young person if a decision has been made to detain him or her.

Several of the facilities had internal guidelines on detaining in connection with or during a placement.

The Ombudsman gave a recommendation to one accommodation facility to ensure that the internal guidelines on detaining in connection with or during a placement are in accordance with applicable rules.

6. Drug tests

6.1. The rules

According to the Act on Adult Responsibility, accommodation facilities can use drug tests when certain conditions are met.

DRUG TESTS

When

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

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

Voluntary participation in specific test
The participation of the child or young person in the drug 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 drug test has been used in a specific situation and be informed of the result of the test. The briefing can take place verbally.

6.2. The use of drug tests

The visited accommodation facilities had used drug tests to a varying extent, from a few tests and up to around a total of 50 tests over the last three years. One visited facility stated that it did not use drug tests out of regard for the relationship between staff and the young people and the facility's pedagogical work.

During the monitoring visits, the visiting teams received the general impression that the facilities were focused on ensuring that drug tests are used in accordance with the applicable rules. It was furthermore the general impression that a test is only carried out in the specific situation if the young person participates voluntarily. However, a few accommodation facilities overlooked that general consent to a relevant extent must be given to drug tests, for instance in connection with the start of the placement.

The Ombudsman recommended to two accommodation facilities to ensure that, to a relevant extent, general consent from the young people is obtained for the use of drug tests, either in connection with the start of the placement or during the placement period, if the need for using tests arises.

The majority of the accommodation facilities were focused on the requirement of informing the custodial parents about the use of a drug test, including the test result. On the other hand, some of the facilities did not or did not consistently inform the placing municipality when carrying out a test.

The Ombudsman recommended three accommodation facilities to ensure that the placing municipality be informed of the use of a drug test and of the test result. For one of the accommodation facilities, this recommendation also included information to the custodial parents.

The Ombudsman generally recommends that it is ensured that drug tests are used in accordance with applicable rules, including obtaining general consent to the use of drug tests, either in connection with the start of the placement or during the placement period, if the need for using tests arises, and that the placing municipality and custodial parents are informed that a drug test has been carried out and of the results of the test.

One of the accommodation facilities stated that the placing municipality is not necessarily informed following each individual test but that the facility sometimes 'pools' the briefings, just as the facility in one instance had agreed with a young person who was tested regularly that he would inform his parents himself.

At a meeting with the Ministry of Social Affairs, Housing and Senior Citizens, the Ombudsman subsequently discussed the question of 'pooling' the briefings and of leaving it to a young person to inform custodial parents. The Ministry has indicated that it is the Ministry's opinion that a briefing must be presumed to take place immediately after the drug test, that it is the placement facility which has the briefing duty and that this duty cannot be left to for instance the young person.

One of the accommodation facilities stated that drug tests are only used when the young people themselves want to have a test carried out, and that the facility does not in those instances brief the custodial parents and the placing municipality of the drug test, as, according to the facility, this would involve a risk of the young people not wanting to take the test. One of the other accommodation facilities also stated that they would not pass on the information in such an instance where the young person asked for a test to be carried out.

On that background, the Ombudsman has discussed the question of the underlying rules for testing in such instances with the Ministry of Social Affairs, Housing and Senior Citizens, and the Ombudsman has subsequently started an own-initiative investigation of the Ministry regarding the scope of the rules on drug tests.

A number of the accommodation facilities had internal guidelines concerning drug tests, and the Ombudsman made two facilities aware of a few matters concerning the facility's guidelines, which should be made clearer.

7. Prevention and handling of alcohol and drug abuse, sexual abuse and self-harming behaviour

7.1. Prevention and handling of alcohol and drug abuse

Several of the visited accommodation facilities received young people with addiction problems requiring treatment while other facilities stated that they do not generally receive young people with an active abuse. All visited accommodation facilities accounted to a relevant extent for the external cooperation with, among others, municipal treatment centres in relation to young people with addiction problems. A few of the facilities had an in-house addiction therapist.

It was the visiting teams' general impression that the facilities were focused to a relevant extent on summoning a doctor for the young people on suspicion of withdrawal symptoms. Some of the facilities stated that they offer alternative treatments against, among other things, withdrawal symptoms, such as NADA acupuncture and hypnosis.

The Ombudsman gave no recommendations concerning prevention and handling of alcohol and drug abuse. However, it was pointed out to one accommodation facility that in connection with withdrawal symptoms, a medical review – and possible treatment – should to a relevant extent be offered to the young people prior to or concurrent with the implementation of alternative treatment forms such as hypnosis and acupuncture. At one of the other facilities, the visiting team indicated to the facility's management that it was the visiting team's assessment that there was a need for an increased focus on withdrawal symptoms and signs of withdrawal symptoms.

7.2. Prevention and handling of sexual abuse

It was the visiting teams' general impression that the visited accommodation facilities to a relevant extent were focused on prevention and handling of sexual abuse. All the accommodation facilities had in-house material on handling of sexual abuse. In this connection, there was a discussion with several of the accommodation facilities on the fact that it is important that the material states, which signs of abuse staff must pay attention to.

At the same time, it was the visiting teams' general impression that the facilities at staff meetings etc. were mindful of talking about suspicions and handling of sexual abuse.

The Ombudsman recommended one accommodation facility to ensure that staff have knowledge of signs of sexual abuse and the procedure to follow on

suspicion of abuse, possibly by clarifying the in-house guidelines on the subject.

Several of the accommodation facilities stated that they have or have had young people who have been victims of sexual abuse prior to the placement, and that there is a focus on ensuring that they receive relevant help during the placement in the form of psychological counselling, among other things.

A few facilities mentioned that they have had young people who sugar dated. In addition, several of the facilities indicated that the young people's behaviour on the internet is a challenge in relation to, among other things, sharing pictures etc., but that the facilities are in general mindful of talking with the young people about good behaviour online.

7.3. Prevention and handling of self-harming behaviour

The majority of the visited facilities stated that they have or have had young people with self-harming behaviour. One of the facilities stated that more or less all the young people placed at the facility exhibit self-harming behaviour at the time of the placement. The primary form of self-harm is cutting.

To a relevant extent, the visited facilities explained that young people with self-harming behaviour have access to psychological counselling and that staff have access to external supervision in relation to the handling of young people with self-harming behaviour.

The majority of the accommodation facilities had in-house material on the subject, and the Ombudsman gave no recommendations concerning prevention and handling of self-harming behaviour. However, it was pointed out to one accommodation facility that the facility should consider drawing up written guidelines on prevention and handling of self-harm and suicide attempts.

8. Health

8.1. 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 facilities accounted for the young people's access to healthcare services, including treatment by general medical practitioner, dentist and specialist doctors. The visits generally left the impression that the facilities were focused to a relevant extent on the young people's health-related conditions and their access to healthcare services.

The visited facilities stated that the young people typically change to the local medical centre or a local general practitioner when they are placed at the facility. Some of the facilities stated that there is often a lack of adequate medical information in the form of health status information etc. for the young people when they arrive, and that it can take some time to get the young person's previous doctor etc. to send the information.

Several facilities indicated that they have a well-functioning cooperation with the psychiatric sector while a few facilities described various challenges in the cooperation with the psychiatric sector in the form of waiting times, lack of evaluation or treatment offers, among other things, for young people who also have an addiction problem.

8.2. Healthcare procedures

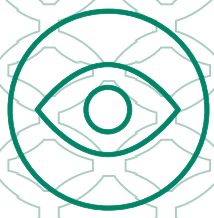
Correct medicines management is crucial to patient safety, and the Danish Health Authority has issued national clinical guidelines partly on drawing up instructions and partly on prescription and management of medicines.

The Ombudsman gave one accommodation facility a recommendation to ensure that the applicable guidelines for healthcare responsibilities are observed, including for medicines management, unintended events and for instruction and supervision of staff. Another accommodation facility was recommended to ensure that the facility's instructions on medicines management and practice concerning medicines management follow applicable guidelines, among other things with regard to dispensing of PRN medicine.

The Ombudsman generally recommends facilities to ensure that medicines management is carried out in accordance with applicable rules and that instructions on medicines management are drawn up pursuant to the Danish Health Authority's guideline on drawing up instructions.

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 institution's monitoring activities in relation to adults and children and for the Taxation Division.

What characterises the Ombudsman's 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 within 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 by the authorities – because the citizens 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 carries out monitoring visits in accordance with section 18 of the Ombudsman Act to especially institutions where people 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 (IMR), 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 is 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 a member of the Ombudsman's staff being present during the whole or part of the deportation. The Ombudsman also reviews the case files of a number of the deportation cases concluded during the preceding year.

Monitoring visits are carried out by Ombudsman staff, in many cases with participation of external collaborative partners or consultants. 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
- a consultant who has a mobility disability
- a consultant who has a visual disability

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 12.7 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 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 interventions and 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 etc. where the themes will be relevant. A theme could be, for instance, disciplinary cells or younger children placed in social care.

After the year's monitoring visits 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 etc. 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 interventions 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.