FOLKETINGETS OMBUDSMAND

The Danish Parliamentary Ombudsman

Gammeltorv 22
DK-1457 Copenhagen K

Tel. +45 33 13 25 12
Fax +45 33 13 07 17

www.ombudsmanden.dk
post@ombudsmanden.dk

United Nations High Commissioner for Human Rights,
Secretariat to the Committee against Torture

sent to:
registry@ohchr.org
cat@ohchr.org

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Enquiries by phone:
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+ encl.

Information from the Danish National Preventive Mechanism concerning the implementation of The Convention against Torture in Denmark

To the members of The Committee against Torture,

In a letter of 14 August 2015 from the Secretary of the Committee against Torture, the Danish Parliamentary Ombudsman as the National Preventive Mechanism of Denmark has been invited to provide the Committee with information concerning the implementation of The Convention against Torture in Denmark.

Please find enclosed the requested information (title of the document: Information from the Danish NPM re. the Danish Government's combined 6th and 7th periodic report).

Our paper is structured as comments and updates to the replies of the Danish Government to the list of issues that the Committee against Torture adopted at its forty-third session (CAT/C/DNK/Q/6-7), i.e. the combined sixth and seventh periodic reports of Denmark (CAT/C/DNK/6-7).

In addition to our paper, and for information, we have attached seven documents consisting of three articles from the our annual reports of 2010, 2011 and 2014 and four thematic reports from 2013 and 2014 relating to the Ombudsman's task as National Preventive Mechanism.

The Danish Parliamentary Ombudsman has accepted the invitation of the Committee to meet on Friday, 13 November 2015. The delegation from The Danish Parliamentary Ombudsman will be consisting of:

- Mr. Jonas Bering Liisberg, Director General
- Mr. Klavs Kinnerup Hede, Director of International Relations

The delegation is very much looking forward to having this opportunity to engage in a dialogue with the Committee and answer possible additional questions from the members of the Committee.

Yours sincerely,
for the Ombudsman

Jonas Bering Liisberg
Direktør

FOLKETINGETS OMBUDSMAND

The Danish NPM's comments in respect of the Danish Government's combined 6th and 7th periodic report to CAT

Contents

1. Introduction

1. In a letter of 14 August 2014 the Committee against Torture (CAT) has asked the Danish NPM to provide comments and relevant information in respect of the Danish Government's combined sixth and seventh periodic report concerning the implementation of the Convention against Torture in Denmark (CAT/C/DNK/6-7, report received by CAT on 23 September 2015).

2. Please note that the Danish Parliamentary Ombudsman has contributed to the preparation of the Danish Government's report. The Ombudsman's contribution concerns paras. 184-185 on the Ombudsman's Children's Division and paras. 220- 227 on the Danish NPM.

3. Please see below for the Danish NPM's comments and updates to the replies of the Danish Government to the list of issues that the Committee against Torture adopted at its forty-third session (CAT/C/DNK/Q/6-7), i.e. paragraphs 9(b), 11(a), 11(b), 11(c), 15, 16, 26 and 28 of the list of issues.

2. Article 10 of the Convention

2.1. Paragraph 9(b) of the list of issues - on identification of torture survivors

4. Paras. 46-54 in the Danish Government's report deal with the question of identification of torture survivors and the Istanbul Protocol. In connection with a visit to Denmark's only institution for detained asylum seekers, the Danish NPM has treated this issue and can provide the following supplementary information:

5. On 28 August 2015, the Danish NPM visited the Ellebæk Immigration Detention Centre (Institutionen for Frihedsberøvede Asylansøgere, Ellebæk). Staff from the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture participated in the visit. The Ellebæk Centre has room for 118 people and a buffer capacity of 18. There were 56 residents at the time of the visit. The staff consist of approx. 49 prison officers, management, works foremen, nurses, office

staff, teacher, pedagogue – a total of approx. 77 staff. Health-care services consist of a physician 15 hours a week (GP from the local area in a secondary job) and 4 nurses on 37, 34, 24 and 18 hours a week, respectively.

6. The NPM's talks with nine residents in all confirmed the impression of a health-care service that is functioning well. However, among the interviewees were two residents with likely traumatization who had not been discovered in connection with the health screening but who had been identified due to the residents' own persistent contact with the health-care system. One of the residents was referred to a psychiatrist and the other was referred to Ellebæk's psychologist who, however, referred the resident on to the nurse with a view to documenting the torture. There was no systematic documentation of torture available in accordance with the Istanbul Protocol, and nor was there any referral to specialised treatment for the after-effects of torture or other sorts of refugee trauma.

7. Among several recommendations which the NPM asked Ellebæk to implement with a view to improving conditions for the Centre's residents was a recommendation that the Centre carry out a compulsory screening as soon as the residents arrive in order to identify victims of torture.

3. Article 11 of the Convention

3.1. Paragraph 11(a) of the list of issues - on restriction in the use of solitary confinement, particularly during pre-trial detention

8. Paras. 60-67 in the Danish Government's report deal with the issue of solitary confinement, particularly during pre-trial detention or remand. The Danish NPM has a special focus on this issue and can provide the following information:

9. On visits to remand prisons and state prisons holding remand prisoners, the visiting team always asks whether there are remand prisoners in court-ordered solitary confinement. Furthermore, in those few

instances where the NPM has encountered inmates in solitary confinement, management and staff are interviewed on how they handle such situations. It is the NPM's opinion that the staff have a good knowledge of the possible damaging effects of solitary confinement. Therefore, the staff pay a lot of attention to the mental condition and needs of the person in solitary confinement.

10. Following visits to state and remand prisons, the NPM has not had occasion to bring up a case against the responsible authorities in relation to the treatment of inmates who are in court-ordered solitary confinement.

11. In order to help ensure that persons in long-term court-ordered solitary confinement are treated correctly and have meaningful social activities, the Danish NPM has made an agreement with the Director of Public Prosecutions that the Director notifies the NPM when the Director receives a request from the police for approval pursuant to section 770d (3) of the Administration of Justice Act. According to this provision, the police shall obtain approval from the Director of Public Prosecutions before requesting the court to extend the pre-trial detention in solitary confinement above eight weeks, or above four weeks if the prisoner is under 18 years of age. When notified of such a case, the NPM will immediately pay an unannounced visit to the institution in question. The agreement was entered into in November 2013, and there has to this date been no notification of any such cases from the Director of Public Prosecutions. The Director has stated that this is not due to a lack of notification of the NPM.

3.2. Paragraph 11(b) of the list of issues - on exclusion from association in state and remand prisons

12. Paras. 68-71 in the Danish Government's report mention exclusion from association pursuant to the Danish Sentence Enforcement Act. Exclusions from association with other prisoners are among the matters which the NPM examines in some detail during the monitoring visits.

13. Prior to visits to state prisons and remand prisons, the NPM receives statistical information on exclusions from association over the last three years – both *voluntary* and *forced*.

14. During the NPM's visits to state prisons and remand prisons, the management is interviewed regarding the reason for long-term exclusions, both voluntary and forced, meaning typically exclusions lasting longer than four weeks but shorter exclusions may also be taken up by the visiting team. Furthermore, the management is asked for information on the conditions under which the exclusion is carried out and on the compensating measures implemented by the management to alleviate as much as possible any damaging effect of the exclusion. For instance, the exclusion may be carried out in such a way as to allow the possibility of association with other inmates in the cells, exercise in the prison yard with other excluded inmates, and other staff-supervised activities.

15. When assessing the exclusion from association the NPM takes it into account when the institution has endeavoured to establish meaningful social relations of a compensating nature for the excluded inmate.

16. Hitherto, the NPM has in certain cases asked for the last three reports on *forced exclusions from association* in order to assess whether there is the statutory documentation for, *inter alia*, the grounds for the exclusion. On the basis of the judgment of 7 January 2010 by the European Human Rights Court (CASE OF ONOUFRIOU v. CYPRUS), the Danish NPM has decided to make a firm practice when visiting state prisons and remand prisons of reviewing the institution's latest three reports on *forced exclusions from association* with a view to investigating whether there is sufficient documentation to fulfil the requirements of the said judgment.

17. With regard to *voluntary exclusions from association*, the NPM will continue the practice according to which the NPM will in certain cases ask for reports on exclusions of a longer duration.

18. In order to help ensure that all prolonged *forced exclusions from association* take place under conditions which do not harm the inmate psychologically, the NPM has made an agreement with the Danish Department of the Prison and Probation Service that the NPM is notified when the Department receives a request from a state prison or remand prison for a decision pursuant to section 63 (9) of the Sentence Enforcement Act. This provision stipulates that exclusions from associations shall not exceed three months but that the Department of the Prison and Probation Service may, however, make a decision to extend the exclusion from association to more than three months in the case of quite extraordinary circumstances. When notified of such a case, the NPM will immediately pay an unannounced visit to the institution in question.

19. The agreement was made in December 2013, and there has to this date been no notification of any such cases from the Department of the Prison and Probation Service. However, upon inquiry the Department has stated that one person has been excluded from association for more than three months but that due to a regrettable error, the NPM was not notified of this. At the same time, the Department has promised to notify the NPM in future on cases of exclusion from association for more than three months as soon as the Department is informed of the case. The exclusion from association in the specific case took place from 20 February 2015 till 27 June 2015, and the NPM will follow up on the case.

3.3. Paragraph 11(c) of the list of issues - on solitary confinement and exclusion from association for juveniles under 18 years of age

20. Paras. 72-74 in the Danish Government's report deal with the issue of solitary confinement of juveniles under the age of 18. Within the last five years the NPM has visited two prisons with special units for juveniles, Western Prison (Vestre Fængsel) with young remand prisoners and Ringe State Prison (Statsfængslet i Ringe) with young people serving sentences. The Ringe State Prison is a closed prison. In 2016, the NPM will visit the open prison Jyderup State Prison (Statsfængslet i Jyderup) which has room for five juveniles under the age of 18.

21. Regarding the Western Prison's unit for young remand prisoners, the visit took place at the end of 2012, and forced exclusion from association was one of the focus points.

22. The NPM's case note on the visit states, *inter alia*, the following concerning exclusions from association:

"On solitary confinement – exclusion from association
In 2011 and 2012 WP [Western Prison] has had two exclusions from association and three temporary exclusions from association.

One exclusion lasted for just under three days and nights while the other lasted for just under ten days and nights. The person who had been excluded from association for ten days and nights was no longer an inmate at WF and, consequently, the visiting team did not have an interview with him.

The other inmate who had been excluded from association for three days did not wish to talk to the visiting team.

We have received all five reports.

[…]

During the discussion regarding the exclusion from association, WF informed us that there is focus on the negative influences of the solitary confinement. Therefore, a young person who is excluded from association is visited for one hour each day by the social education worker and twice a day for about 15 minutes by a juvenile-liaison officer. Furthermore, the young person's one-to-one tuition is allowed to continue. The young person is of course allowed exercise in the prison yard every day. There is access to television, books and newspapers.

Consequently, the overall conclusion is that the specific exclusions from association on which we have received copies of reports observe the Danish rules and, in my opinion, take place under acceptable conditions."

23. On the final interview with the management regarding the conditions for the young persons during their exclusion from association, the NPM's case note states:

"The management stated that the social education worker comes once a day for one hour and that the young person is visited by one of the juve-

nile-liaison officers twice a day. In practice, the young persons also have social contact with others, as they communicate through the windows. No measures are taken against this. One-to-one tuition continues in the cell. The ten days exclusion which we had noted in the list was quite exceptional, and nobody could remember the last time this had happened.

In addition, when the young persons are put in prison, they meet with the juvenile-liaison officers who explains to them what is expected of them and what may happen in the form of force and exclusion from association."

24. The visit gave occasion for oral recommendations to the prison management but not for written questions to the responsible authorities.

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25. In September 2015, the NPM visited Ringe State Prison which has a unit for young persons under the age of 18 who is serving a prison sentence. In the NPM's case note on the visit, the following is stated regarding the young persons unit:

"Section 6 is the juvenile unit. It was stated during the rounds that the unit is standardised for five and has room for six inmates. There are at present four inmates. The unit is primarily for young persons under the age of 18 but older inmates may also be placed there, subject to individual assessment. At the moment, a 20-year-old inmate with good behaviour is placed there. Some of the inmates have previously been placed pursuant to section 78 of the Sentence Enforcement Act. The young persons unit is a sort of last option. Two of the inmates have been reported for radicalisation.

The unit receives an extra state grant for employment of teachers and pedagogues, as many of the young persons need one-to-one tuition. Only a few have passed a 9th form level examination. The inmates struggle with various diagnoses and below-average intelligence as low as an IQ of 66."

26. The visit did not provide grounds for a separate investigation of exclusions from association for young persons under the age of 18, and the general investigation of the prison's practice concerning exclusions from association did not give rise to recommendations to the management.

3.4. Paragraph 15 of the list of issues - on women in remand prisons and certain state prisons

27. Paras. 95-103 in the Danish Government's report deal with the issue of conditions for women in state prisons and remand prisons, as Denmark does not have any state or remand prisons solely for women. The Danish NPM and the Ombudsman have had special focus on this issue over the years and can on this basis state as follows:

In general

28. When the NPM visits state prisons and remand prisons, the management and staff are always interviewed regarding the conditions if there are female inmates in the same institution as male inmates. Furthermore, female inmates who wish to speak with the NPM are asked about general conditions for female inmates.

29. For information please see the enclosed article in English, 'Women in Prison', published in the Parliamentary Ombudsman's Annual Report for 2011.

Institutions in Denmark

30. In 2015, the NPM has visited two state prisons holding both men and women: the Herstedvester High Security Institution (Anstalten ved Herstedvester) and the Ringe State Prison. In addition, the NPM has visited the Ellebæk Immigration Detention Centre.

31. The Herstedvester High Security Institution has a separate section for women (unit R/S) which the Danish NPM saw in connection with a visit to the institution on 18 and 19 February 2015. The management provided the following information, *inter alia*, regarding the women's unit:

- *that* women may choose to serve their sentence without any contact with male inmates, but that several women choose contact with the men – both during work and leisure hours

- *that* physical conditions for women were improved some years ago, and that occupational opportunities were established at unit R/S together with the possibility of sectioning. The female unit's workshop employs between three and six inmates daily

- *that* a shielded area has been established for women who wish to have outdoor exercise without contact with the male inmates

– *that* the institution experiences difficulty in ensuring that any relationships between male and female inmates are voluntary. Several of the female inmates suffer from mental illness, substance abuse, and have problematic social and family relationships. Consequently, they are often not very good at being selective when it comes to, *inter alia*, choosing a partner

– *that* the women enter into romantic partnerships and marriage during their stay in the institution. The institution does not try to prevent this if the institution believes that the relationship is voluntary, even when it may not from an outside perspective seem to be a healthy relationship

– *that* inmates with romantic partnerships/marriage with other inmates may apply for in-house conjugal visits and thereby use a visiting room for a few hours a week, if the institution deems that it is justifiable from a security perspective

– *that* the institution offers the women participation in the programme “strengthen and win” developed to train the women in their own situation and in making the right choices

32. During the visit the NPM spoke with three female inmates. One of them was married to a fellow inmate and the other two had partners within the institution. The three women stated that it is possible for women not to be bothered in the institution if they indicate clearly from the start – to both men and women – that they are not interested, no matter if they have a partner in the institution or not. It was the opinion of the three interviewees that the women who are for instance cat-called themselves “play up to” the men and seem interested. One of the women stated that she had dropped out of the mixed workshop because several of the men kept sending her flowers. Two of the women had children and therefore used the visiting apartments for 47 hours once a month for visits.

33. Overall, the NPM found no grounds for contacting the responsible authorities regarding conditions for women at Herstedvester.

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34. Ringe State Prison has a separate women’s unit, and the NPM’s visit to the state prison on 23 and 24 September 2015 showed that men and women are kept segregated in separate units. Men and women are also segregated with regard to occupational activities. However, a married couple who are serving their sentence together are

placed in the women's unit. The NPM did not receive any information that the man's presence in the women's unit caused any problems. At Ringe State Prison, it is also possible to include a child under the age of three when serving a sentence if it is deemed not to be contrary to the child's welfare. At the time of the NPM's visit, there was one woman in the prison's treatment ward who had a child with her. The treatment ward is open to both men and women and is on a voluntary basis.

35. Conditions for women at Ringe State Prison did not give the NPM cause for contacting the responsible authorities.

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36. Prior to the monitoring visit to Ellebæk Immigration Detention Centre, the NPM had received information that, *inter alia*, female residents at the Centre were harassed by the male residents. During the visit it was noted

- *that* the women's section was appropriately separated from that of the men

- *tha*t the staff had their focus on those male residents who harassed female residents and took the necessary preventive actions towards these men

- *that*, according to the management's statement, such problems did not occur very often

- *that* women only have contact with men in the production hall which is staff supervised, and only if the women wish to do so

- *that* women together with under-age boys are given priority access to the creative workshop, and

- *that* the women's section was significantly cleaner and in better condition than the men's section.

37. At the time of the visit there were a total of 56 detainees at Ellebæk of which three were women. None of the women wished to have an interview with the NPM. Together with a received complaint, the visit caused the NPM to contact the responsible authorities, but not about the conditions for women.

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38. The NPM has encountered women in a few instances when visiting remand prisons. All women whom the NPM has spoken with have stated that it is not a problem to be remanded in custody together with men. During visits to remand prisons with female inmates, staff has focused on the women's safety. Over 2013, the Prison and Probation Service has tightened safety for the vulnerable inmates, including women, so that some remand prisons which used to practice an "open door" regime now follow the guidelines applying to remand prisons. The rules do, however, imply that women are allowed to be together with men in their cells during leisure hours. The association is conditional on joint consent and on the management's assessment that the association is not putting the woman at risk. If the association is allowed, it will take place in the man's cell and never in the women's cell.

Institutions in Greenland

39. In 2013, the Ombudsman visited institutions in Greenland under the police and the Prison and Probation Service, and the focus of these visits was, *inter alia*, the question of conditions for women. The visits gave the Ombudsman cause to contact the authorities.

40. During the visits, the Ombudsman was informed that several of the institutions did occasionally hold female inmates and that, furthermore, the correctional facility in Nuuk had a separate prison unit for women.

41. As a follow-up to the visits, the Ombudsman asked in a letter of 29 December 2014 the Greenland Prison and Probation Service (Central Administration) and the Department of the Prison and Probation Service for a statement on, *inter alia*, the institutions' management of conditions for female inmates.

42. Firstly, the Ombudsman asked the authorities to state whether there were any registered incidents in 2013 and 2014 where female inmates had complained of assault or where there was other information about assault on female inmates.

43. It appears from the authorities' replies that in 2013 one complaint about assault by a male inmate on a female inmate had been registered. The case was reported to the police but the case was closed for lack of evidence. According to the authorities, no other incidents of assault on female inmates had been registered in 2013 and 2014.

44. Secondly, the Ombudsman asked the authorities to state whether the Prison and Probation Service takes measures to prevent that

female inmates become victims of assault during their stay in the institutions.

45. It appears from the authorities' replies that the Greenland Prison and Probation Service has two units especially designated for women, one of which is the abovementioned unit at the Nuuk Correctional Facility with 6 places, and the other is the Ilulissat Correctional Facility, also with 6 places. In both facilities the women are shielded in relation to the male inmates. The female inmates may, on request, be allowed to visit male inmates.

46. In relation to the women's unit at the Nuuk Correctional Facility, the authorities stated that it was decided when the unit was established that the women would, as a starting point, be totally separated from the men – both during work and leisure hours. It appears from the authorities' statements that it had come to light in connection with the Ombudsman's inquiry that since the autumn of 2014, the facility had not fulfilled the target of separate occupation which was corrected immediately, according to the authorities.

47. Regarding the Ilulissat facility, the authorities stated that the main facility had been closed down for rebuilding and extension which meant that the inmates had been placed in an exceptional situation. According to the authorities, the facility will be in full use in 2015, and special occupation for women (needlework) will then be established. In addition, the authorities stated that according to their own wishes, women may participate in activities which include male inmates and that these activities will be supervised by staff.

48. With respect to the other correctional facilities, the authorities stated that a total of 31 cells with own bath and toilet have been established in connection with the adding of more places at Greenland facilities over the most recent years. According to the authorities, this means that female inmates at the Sisimiut, Aasiaat and Tasiilaq correctional facilities now have a better chance of having access to their own bath and toilet.

49. Furthermore, the authorities stated that there is no separation between women and men during occupational activities and teaching at the other correctional facilities but that such activities are always supervised and run by staff.

50. Finally, the authorities stated that the correctional facilities as a general norm are aware of the need for an increased staff presence in

the places where there are female inmates – for instance in communal living rooms, kitchens, etc.

51. In addition, the authorities have stated that the Prison and Probation Service of Greenland will soon formulate a practice direction to staff on the treatment of female inmates, which applies to all correctional facilities on Greenland.

3.5. Paragraph 16 of the list of issues - on asylum centres, etc.

52. Paras. 104-115 in the Danish Government's report mention a number of changes for asylum seekers in Denmark. In addition to this, the NPM can provide the following information:

Persons on 'tolerated residence status' at Center Sandholm

53. In 2012 and 2014, the Ombudsman carried out monitoring visits to Center Sandholm together with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture. The purpose of the monitoring visits was to assess general conditions for persons on 'tolerated residence status' and residing at Center Sandholm. According to the Danish legislation, persons can be given "tolerated residence status" if they are not eligible for residency or asylum but cannot be expelled due to the risk of torture or death penalty upon expulsion.

54. The monitoring visit in 2014 concerned a group of 25 persons who had been on 'tolerated residence status' with residential obligation at Center Sandholm since 2012 or earlier.

55. Persons on 'tolerated residence status' at Center Sandholm are subject to a number of restrictions, for instance a residential obligation at the centre (often in rooms shared with one or two others), a reporting obligation to the police (typically every day), they are not allowed to take paid work, and they receive limited pocket money (a maximum of just over DKK 31 a day). They are given meal vouchers for the centre's canteen. In principle, they can cook their own food but in reality the possibility of doing so is very limited because of the limited financial means at their disposal. There are no limits to the duration of a 'tolerated stay'.

56. Overall conditions for persons on 'tolerated residence status' at Center Sandholm – in light of the indefinite time aspect – were deemed by the Ombudsman to be very stressful and restrictive for a normal life. General conditions were not, however, held to constitute a violation of the prohibition on degrading treatment pursuant to the UN

Convention against Torture and the European Human Rights Convention.

57. Nevertheless, in the Ombudsman's opinion there was reason for the responsible authorities to consider in more general terms the extent to which it is necessary to maintain in all respects such overall stressful and limiting living conditions. An article on the case in an English translation and published in the Parliamentary Ombudsman's Annual Report for 2014 is enclosed for information

On the deportation of a child and the child's grandmother – visit to Center Kongelunden

58. Center Kongelunden is an asylum centre which is a specialised centre for asylum seekers who are in need of care above the care given to all asylum seekers. During a visit in February 2014, the NPM was notified of a case where a boy and his grandmother who had been residing at the centre had been deported from Denmark.

59. The case concerned the 10-year-old boy and the boy's grandmother who was the boy's guardian. In March 2011, they were refused asylum in Denmark. In September 2011, the residential municipality decided to place the boy in an institution. The purpose of the placement was to investigate whether the boy was at risk of serious damage to his health and development. It was, *inter alia*, doubtful if the grandmother was capable of taking sufficient care of the boy. In addition, the municipality applied on behalf of the boy and the grandmother for a residential permit according to section 9c (1) of the Danish Aliens Act which says that a residential permit may be issued to a foreign national if exceptional reasons, including regard for family unity, make it appropriate. In October 2011, the Danish Immigration Service refused that the boy and his grandmother could submit an application for residence permits while staying in Denmark according to the provision of section 9c (1), cf. (5) of the Aliens Act, then in force. The Immigration Service did not find that Denmark's international obligations required that the application could be submitted in Denmark. In addition, the Immigration Service informed the Danish police that the boy and his grandmother could be deported from Denmark whereupon they were both deported to Serbia together.

60. On the basis of this information, the Ombudsman asked the Ministry of Justice to send him the documents in the case.

61. The Ombudsman had been interested in this issue previously. In June 2011, the then Ministry of Immigration had, *inter alia*, stated that children placed in care must be presumed to be in need of the protection

of the Danish State, cf. the UN Convention on the Rights of the Child and Article 3 on the ban on torture and other inhuman or degrading treatment and Article 8 on the right to family life of the European Human Rights Convention, meaning that the children therefore in relation to Article 8 of the European Human Rights Convention cannot normally be asked to take up residence in another country, not to mention leave the country with their parents.

62. The Ombudsman expressed the highest form of criticism of the fact that the Immigration Service had refused to allow the boy and his grandmother to apply for a residence permit while staying in Denmark, and that the Immigration Service consequently informed the police that there was no obstacle to deporting them from Denmark.

4. General information on the national human rights situation, including new measures and developments relating to the implementation of the Convention

4.1. Paragraph 26 of the list of issues - on the Children's Division within the Ombudsman's office

63. As an up-date to the information given in the Danish Government's report, paras. 184-185 on the Children's Division within the Ombudsman's office, the NPM can provide the following details:

64. The Children's Division carried out 11 monitoring visits in 2014: Four visits to social institutions with in-house schools; two visits to secure institutions with in-house schools; two visits to social care institutions without in-house schools; one visit to a family institution; and two visits to foster families.

65. The Children's Division carried out 10 monitoring visits in 2015. All the visits went to residential institutions for children with mental and often also physical disabilities where the children had very limited or no verbal language. One of the institutions had an in-house school.

4.2. Paragraph 28 of the list of issues - on the Danish NPM

66. In addition to the information given in the Danish Government's report, paras. 220-227 regarding the Danish NPM, please note that the NPM has carried out 24 visits in 2014 and 40 visits in 2015. A target figure has been agreed in-house for the number of visits to be carried out. The target figure has been set at a minimum of 40 visits per year. Likewise, a target figure has been set for the number of forced re-

turns, which the Ombudsman monitors, cf. para. 227. The target figure has been set at 10 forced returns.

67. Furthermore, please note that the NPM's monitoring visits include investigation of conditions at the institutions in question, partly in relation to a number of general focus points and partly in relation to one or more specific themes. In addition, during a visit the NPM may look into conditions which are not covered by a focus point or a theme, if the situation warrants it.

68. Focus points are issues which are generally supposed to be of special importance to persons who are deprived of their liberty. The focus points are:

1. Use of physical force towards the inmates or residents
2. Use of other measures towards the inmates or residents
3. Inmates' or residents' social relationships, including interaction among themselves, interaction with staff, and interaction with the outside world. The NPM will look into, *inter alia*, any occurrence of violence and intimidation by the staff and among inmates or residents themselves
4. How the serving of a sentence or the stay is organised, including the possibility of work, training, leisure time, exercise, physical training, addiction treatment and not least a health care service equal to that on offer for the rest of the population
5. Sector transfer problems, meaning the collaboration between various authorities and institutions, for instance between state prisons and remand prisons on the one hand and on the other hand social authorities, mental health services and the police, which are of importance to the inmate not only during the imprisonment but also after his or her release.

69. As mentioned above, the NPM does not only work with focus points but also with themes. A theme is selected, a topical subject which changes from year to year. In 2015, the NPM had chosen two themes, one of which was the use by state and remand prisons of security cells. This theme was selected because the Danish High Court in a judgement of 4 June 2014 had found that the Prison and Probation Service had treated an inmate inhumanely in connection with the use of security cells. The judgment is mentioned in the Danish Government's report in paras. 199-201. In 2013 the themes were addiction treatment and prevention of inter-user violence and intimidation, whereas in 2014 the themes were prevention of suicide and suicide attempts and psychiatry. For information about the themes of 2013 and 2014, please see the attached four thematic reports.

70. Finally, please be advised that the NPM in 2009/2010 investigated matters concerning administrative detention of protesters by the police during the climate summit in Copenhagen in December 2009 (COP 15) which led to the Danish courts finding against the police regarding human rights violations, as mentioned in the Danish Government's report in paras. 195-198. The NPM's investigation concluded that the actions of the police constituted degrading treatment in violation of human rights requirements. Danish courts later reached the same conclusion. The NPM issued the police with a number of recommendations on the use of such detentions in the future. An article on the case in an English translation and published in the Parliamentary Ombudsman's Annual Report for 2010 is enclosed for information.

THE DANISH
PARLIAMENTARY
OMBUDSMAN

Annual Report

2010

Erik Dorph Sørensen
Head of OPCAT Unit

BAPTISM BY FIRE FOR NEW UNIT DURING CLIMATE SUMMIT

On 7-18 December 2009, the UN held a climate summit (COP15) in Copenhagen. The police had been notified of and approved many demonstrations. Some organisations had announced that they might resort to illegal methods during the demonstrations. In turn, the police said that it was well prepared, and the police had, among other things, established temporary waiting rooms – the so-called climate cages – at Retortvej in Valby. In addition, before the summit Parliament had changed the provisions of the Police Act concerning preventive arrests, allowing demonstrators to be detained for up to 12 hours as against 6 hours previously.

The largest demonstration, with almost 100,000 participants, took place on Saturday 12 December 2009. It was a cold day with temperatures around freezing. A group of possibly up to 300 people began to commit vandalism, smashing shop windows and setting off fireworks. In their attempts to escape from the police, they mingled with the tail end of the large demonstration. At 3.26 p.m., the police detained just over 900 people at Amagerbrogade. The detainees were handcuffed with plastic handcuffs with their arms behind their back and made to sit in long rows on the asphalt.

From Amagerbrogade, the detainees were to be taken by bus to the climate cages at Retortvej. However, there were insufficient buses to transport so many to Valby. The final detainees were not taken away until 8 p.m., after almost 4½ hours at Amagerbrogade.

During the 4½ hours, many had no access to a toilet, but had to remain seated on the asphalt. The detainees were not given food or water or anything to sit on, even though it was so cold. However, some people were given water by policemen at Amagerbrogade and a few were able to go to the toilet at nearby pizzerias etc.

No doctors were present, but around 6 p.m. – 2½ hours after the first detentions – the police called a doctor and ambulance for a person who had cramps. The person was released after treatment. The doctor pointed out to the police that it was too cold to sit on the ground and asked for the detainees to be removed from the ground. The police then took some of them for a walk.

The detainees could not contact relatives or a lawyer until they reached the climate cages at Retortvej.

During the 4½ hours at Amagerbrogade, the police did not undertake registrations or interrogations. However, after a short while, the police released 200-300 persons who clearly did not belong to the group they wished to detain.

The police action was extensively covered by the media – also internationally. In the subsequent days, the Parliamentary Ombudsman received a number of complaints from citizens dissatisfied with the police approach. The Ombudsman's new OPCAT Unit therefore decided to investigate the general treatment of the detainees by the police.

OPCAT – THE NEW INSPECTION UNIT

As a new responsibility, the Ombudsman now undertakes so-called OPCAT inspections and investigations based purely on human rights considerations. Unlike the Ombudsman's ordinary inspections, the OPCAT Unit draws on medical expertise from the Rehabilitation and Research Centre for Torture Victims and obtains expert knowledge about human rights from the Institute for Human Rights. Unlike the ordinary inspections, the OPCAT inspections may also be carried out in private places where people may be confined, such as social homes. The inspections and investigations must be future-oriented and result in recommendations for improvements to the authorities. In summer 2009, the Ombudsman Act was amended, partly with a view to giving the Ombudsman the necessary competences as an OPCAT authority.

OPCAT inspections are carried out by a special Ombudsman unit comprising three lawyers and a member of office staff, equalling a total of 2½ full-time jobs. The unit was established in 2008 to ensure that Denmark complies with UN's so-called 'OPCAT protocol' (Optional Protocol to the Convention against Torture), which was ratified by Parliament in 2004. The OPCAT protocol requires participating states to establish a system of regular visits by independent bodies to places where people are or may be confined. The purpose is to prevent torture and other cruel, inhuman or degrading treatment or punish-

ment. Each participating state is obliged to establish one or more national authorities for the prevention of torture etc.

In collaboration with the Rehabilitation and Research Centre for Torture Victims and the Institute for Human Rights, the OPCAT Unit undertook nine inspections in 2009 and 20 inspections in 2010. The inspections were carried out in detentions rooms for intoxicated persons, gaols, prisons, closed psychiatric wards, homes for the mentally retarded and one boarding house run by the Prison Service. The inspections were targeted towards four areas: the relationship between inmates/patients/residents and employees, the use of isolation, medical matters and the extent to which force was used. In 2011, the OPCAT Unit expects to undertake 40 inspections.

It soon became clear that an investigation of the situation on 12 December 2009 fell more naturally under the OPCAT Unit than the Ombudsman's department for ordinary inspections. This was partly because several hundred of the detainees had immediately stated that they wanted the courts to test the legality of their detention by the police. The Ombudsman traditionally does not enter cases with special access to being tested by submission to a court, but the OPCAT mandate provides an opportunity to assess circumstances with a view to the future and to make recommendations for possible improvements to the authorities without taking any court judgments about legality into consideration. When detaining people, the police must respect human rights, irrespective of whether the detentions are legal or not.

The information in the media and the citizens' approaches to the Ombudsman about the events moreover suggested that the treatment of certain citizens might have endangered their health. This indicated that it might be necessary to include medical expertise in the investigation.

THE OPCAT INVESTIGATION

On Tuesday 15 December 2009, three days after the large demonstration, the OPCAT Unit wrote to the Copenhagen Police to request answers to a number of questions about the climate cages at Retortvej.

On the same day, at around 2.30 p.m., the OPCAT Unit, with a doctor from the Rehabilitation and Research Centre for Torture Victims, carried out an unannounced inspection of the climate cages, which had been erected in a disused production hall at Retortvej in Valby. There were no people in the cages during the inspection. Twelve cages were intended for eight persons and the remain-

ing 25 for ten. There was sufficient room for everyone to lie down. There were 18 toilets and, according to the police, everyone who needed to visit the toilet was able to do so within a reasonable period of time. Asked whether the just over 900 people detained on 12 December 2009 were able to visit the toilet, the police said: 'Certainly there were no accidents and nobody waited more than an hour.' There were many pallets with water in plastic bottles and numerous mats and blankets in the production hall. The hall was also very well heated. According to the police, everybody had been given water in plastic bottles on request as well as a chicken sandwich on 12 December 2009. In addition to the cages and toilets, there was a registration section with approx. ten counters. Here all detainees were given a guide to their rights before they were locked in the cages. The guide was in five different languages. At registration, everyone was allowed to call a relative or a lawyer – either on their own mobile phone or using the police telephone. The production hall also had a separate, screened-off sick bay, which was manned by doctors on 12 December 2009 and after that according to need. On that day, the police had also ensured that the 24-hour Social Service was available to look after any children.

The climate cages only had room for approx. 350 people, so they were inadequate for the just over 900 people who were bussed from Amagerbrogade to Retortvej on 12 December 2009. According to the police, approx. 600 persons were registered while sitting on the buses and subsequently released without being detained in the cages. They were released on a continuous basis and driven to nearby metropolitan train stations.

In its reply to the OPCAT Unit's written questions about the waiting rooms, the police subsequently confirmed the findings of the inspection. The police also provided the OPCAT Unit with many other details for use in its investigation of the police's handling of the detainees.

On Friday 18 December 2009, the OPCAT Unit asked the Copenhagen Police to reply to a number of questions about the police's handling of those detained in connection with the demonstrations during the climate summit, especially the largest demonstration at Amagerbrogade.

In its reply, the police confirmed among other things that 600-700 people had to wait for more than an hour at Amagerbrogade, that the police had not organised water, food or something to sit on and that a doctor and ambulance had not been called for the detainees until a person got cramps after sitting for approx. 2½ hours on the ground at Amagerbrogade. In addition, the police confirmed that it was correct that the detainees – with a few exceptions – were not able to visit a toilet.

The police information was included in the investigation together with the full explanation submitted by the National Commission of the Danish Police to the Legal Affairs Committee in February 2010.

NEW POLICE GUIDELINES

In July 2010, the OPCAT Unit's report was completed. It established that the climate cages provided sufficient heating, water as needed, the opportunity to visit the toilet within a reasonable period of time, access to telephone contact with the outside world and food for those waiting in the cages for some time. In addition, the climate cages were large enough for everyone to lie down on the mats handed out, and detainees were given written information about their rights. The conclusion was therefore that neither the conditions in the police climate cages nor the police procedures at the cages constituted an offence against basic human rights – as long as the cages were only used for short-term detention.

However, on the basis of the OPCAT Unit's inspection, the police changed the procedure for medical services so that at future detentions, detainees suffering from chronic illness will have access to their medication already at registration.

By contrast, the police detention of the many people at Amagerbrogade was not acceptable. The OPCAT Unit recommended that at similar future events the police should follow different procedures to those at the COP15 demonstrations in several respects. The OPCAT Unit's recommendations for the future were:

- that detainees should be given the opportunity to visit the toilet within a reasonable period of time
- that it was made regular practice to arrange water and something to sit on at events which may lead to mass detentions
- that medical competence should be provided at such events to minimise the risk of endangering the health of those detained/confined
- that at such events the police should carry out the necessary interrogations as quickly as possible so as to reduce the detention time to a minimum.

At the end of November 2010, the Ministry of Justice replied that it endorsed all the OPCAT Unit's recommendations and that the police would incorporate the recommendations into the guidelines for the police effort in connection with large demonstrations.

On 16 December 2010, the Copenhagen City Court pronounced judgment in relation to 250 of those detained. The Court stated that the detention was illegal and that conditions for 178 people had contravened Article 3 of the European Human Rights Convention, which prohibits torture and other cruel, inhuman or degrading treatment or punishment. The prosecution appealed the judgment and the case is still pending at the High Court.

THE DANISH
PARLIAMENTARY
OMBUDSMAN

Annual Report

2011

Lennart Frandsen
Head of 3rd Division
(Inspections)

WOMEN IN PRISON

> 'It is clearly unacceptable that mentally ill women are compulsorily placed in a situation where they feel pressurised into marrying a male prisoner – possibly a prisoner sentenced for a very serious and dangerous sexual crime.'[1]

The Act on the Execution of Sentences and the administrative provisions issued under the authority of the Act contain a number of rules protecting the legal rights of prisoners and their conditions generally. The rules apply to persons in state prisons and as a starting point also to those detained in local prisons and Prison and Probation Service halfway houses.

Detailed legal guarantees apply to the individual measures which may be implemented in relation to prisoners. The purpose is of course to ensure that prisoners can live at the institutions without inconveniences beyond those which follow from the deprivation of liberty itself. In the legislative history behind the Act on the Execution of Sentences it is stated in this connection that no restrictions should be made to the prisoners' lives beyond those necessary for the implementation of the deprivation of liberty imposed by the sentence. The deprivation of liberty is only intended to affect local freedom.

RELATIONS AMONG PRISONERS

The Act on the Execution of Sentences and the administrative provisions thus govern the relationship between the State (the Prison and Probation Service) and prisoners, with a number of rights, guarantees, etc. intended to ensure that prisoners can serve their sentences with as few problems as possible. However, what about relations among the prisoners themselves? There are virtually no

1 Parliamentary Ombudsman Report for 1996, p. 380

written regulations in this respect. And it is a fact that many prisoners experience many and serious problems in relation to other prisoners.

There may be problems between various groups in relation to:

- prisoners from different ethnic backgrounds
- young people
- drug addicts
- foreigners
- prisoners serving sentences for particular crimes (crimes involving children)
- women

In a way it is paradoxical that the Act on the Execution of Sentences and the administrative provisions aim to protect prisoners' rights etc. in relation to the authorities executing their sentence if the reality is that the lives of inmates in state and local prisons are mainly dominated by abuse, threats, etc. by other inmates.

These matters attract particular attention in the processing of complaint cases and especially at the Parliamentary Ombudsman's inspections. Questions are asked about them and the angle is that the authorities are under an obligation to protect particularly vulnerable groups and individuals in prisons. It is, however, extremely difficult for the authorities to prevent abuse, threats, etc. effectively and it is an illusion to believe that the Ombudsman's inspection activities can reveal and relieve such problems to any significant extent. Nonetheless, the Parliamentary Ombudsman should continue to pay attention to these problems, and so he does during inspections of the institutions of the Prison and Probation Service.

In this article, I have chosen to consider the vulnerable group consisting of women.

WOMEN IN PRISON

In Denmark, there are on average 170 women detained in state and local prisons, corresponding to approx. 5 per cent of all prisoners. As is also the case for male prisoners, the length of their sentences varies greatly, from 7 days to life.

There is no separate women's prison in Denmark. The only women-only prison – the low-security women's prison in Amstrup with room for 20 prisoners – was

closed in 2000, incidentally after an inspection by the Parliamentary Ombudsman in 1998. Among the reasons for the closure was that the inspection revealed that the prison was in an extremely poor structural condition.

Women are received at all local prisons, including those in Copenhagen. Five state prisons receive female prisoners: Ringe State Prison, Horserød State Prison, Møgelkær State Prison, Eastern Jutland State Prison and Herstedvester Prison. In other words, female prisoners serve their sentences together with male prisoners. Danish legislation does not contain provisions specifying that women and men have to serve their sentences in separate institutions. European prison rules lay down that the need to separate male and female prisoners must be taken into consideration when deciding to house prisoners in particular prisons or prison blocks.

MEN AND WOMEN TOGETHER

The question is whether it causes problems for women that female prisoners serve their sentences together with male prisoners in Denmark. The short answer is: yes, it causes major problems. For space reasons, I will only consider the conditions of female prisoners at Herstedvester Prison.

Herstedvester Prison has a special women's block with room for 14 women (now distributed in two sections). During their imprisonment, the women serving sentences for serious crimes are offered treatment by psychiatrists and psychologists, among others. The women are able to spend time with male prisoners in the workshops and during their leisure time.

The women's block has been inspected by the Parliamentary Ombudsman on several occasions and the Ombudsman has monitored the women's conditions on a regular basis. The problems were/are due to the fact that the women are serving their sentences in the same institution as some of the worst male sexual offenders in the country. A recommendation by a Prison and Probation Service working group considering 'vulnerable' prisoners in the institutions of the Prison and Probation Service which was issued in March 1996 also considers the conditions of women. In relation to female prisoners being housed at Herstedvester Prison, the Prison's chief medical officer at the time, Heidi Hansen, wrote, among other things, in a minority statement:

> 'On the basis of the experiences gained by the institution since the establishment of the women's block, it is considered a cause for grave concern that women are housed among the male prisoners at all.

Just under half of the prisoners are serving sentences for very serious sexual crimes. On 26 October 1995, 56 sexual offenders were serving their sentences at Herstedvester Prison. Of these, 31 had received sentences of indefinite imprisonment, six were serving eight to 16 years and only 19 less than eight years. This in itself shows that the sexual offenders at Herstedvester Prison have committed very serious sexual crimes. It is obvious that persons guilty of such serious crimes have major problems managing their sex drives and for this reason alone it is a cause for grave concern that female prisoners have to serve their sentences with them. In addition, relatively many of the sexual offenders at the prison can only be granted a pardon or be conditionally discharged or released if they accept medical castration, a treatment which it has in several cases been difficult to motivate the prisoners to consider, partly due to influence by some of the female prisoners.'

INITIATIVES BY THE PARLIAMENTARY OMBUDSMAN

In his final report of 13 May 1997[2] of an inspection of the women's block at Herstedvester Prison on 13 and 16 December 1996, the Ombudsman stated, among other things:

'It is clearly unacceptable that mentally ill women are compulsorily placed in a situation where they feel pressurised into marrying a male prisoner – possibly a prisoner sentenced for a very serious and dangerous sexual crime.

The Prison and Probation Service is responsible for ensuring that sentenced women who need psychiatric/psychological assistance are offered such help in an institution where there is no risk that they are exposed to pressure to marry a man sentenced for a serious sexual crime. This should be achieved without resulting in any negative effect on the female prisoners' employment and education opportunities.

I do not regard it as my place to suggest what solution should be implemented to establish such conditions.

I recommend that the Department of the Prison and Probation Service find a solution as soon as possible to the above-mentioned problem and I ask to be informed of further developments in the case.'

On the basis of the Ombudsman's recommendation, the Department of the Prison and Probation Service established a new women's block in the Prison. The new block consisted of two separate sections with room for six and eight prisoners, respectively. In the new block, the women were still able to serve their sentences separate from the male prisoners, but now this also applied to some extent to leisure time, prison yard exercise, employment and education.

Initially, the Parliamentary Ombudsman therefore took no further action in the matter, but asked the Department of the Prison and Probation Service for

2 Parliamentary Ombudsman Report for 1996, pp. 363-399 (esp. pp. 380-381)

information about the annual assessments of the women's conditions. The Department's assessments were that their conditions could still be problematic, but had improved significantly.

On 26 October and 5 November 2004, the Parliamentary Ombudsman visited the women's block again. In his report of 28 January 2005[3] on the visit, the Ombudsman stated, among other things:

> 'During my conversations with several of the female prisoners at the institution, I was thus informed that the female prisoners find it difficult to avoid the attention of the male prisoners and that they are often addressed or accosted in an unsuitable way by the male prisoners – for instance with indecent comments during prison yard exercise and services. Even those of the women who have a boyfriend or husband at the prison (or outside) are not always left in peace. I was also informed that several of the female prisoners do not tell staff when they are accosted by male prisoners – partly because they are afraid of reprisals by the male prisoners. The female prisoners in Block S stated that they have to be constantly on the alert in relation to the male prisoners.'

During the inspection, it was again stated that it was not only the female prisoners who were to some extent affected by the structure – it also affected the male prisoners. Among other things, it was thus (still) a problem in relation to the treatment of some of the male prisoners, as they did not wish to start treatment with sex-drive reducing medication because they were in a relationship with a female prisoner.

After further exchanges of letters with the Department of the Prison and Probation Service, the Ombudsman stated in a letter of 15 August 2005[4] that the offer given to the women to serve their sentences separate from the male prisoners could not be regarded as a genuine offer enabling them to serve their often long sentences in accordance with the Act on the Execution of Sentences. It had turned out that none of the women took up the opportunity to serve their sentences separate from the male prisoners due to the conditions under which they would then have to serve their sentences, for instance in relation to employment, education and leisure offers. The Ombudsman stated that the necessary solution, at least in the longer term, would be the establishment of a completely separate women's block with separate workshops and leisure facilities. The Ombudsman also asked whether the Department had considered or was prepared to consider obtaining funding to establish a completely separate block for women with adequate employment and leisure offers at or by Herstedvester Prison.

3 Parliamentary Ombudsman Report for 2004, pp. 671-694 (esp. p. 678)
4 Parliamentary Ombudsman Report for 2004, pp. 690-691

In May 2006, the Department of the Prison and Probation Service therefore initiated an elucidation project in which the issue of establishing a completely separate women's block was considered. A research project about female prisoners in Denmark was also initiated.

DKK 16 MILLION GRANTED FOR BUILDING IMPROVEMENTS

Due to the intense attention paid to the conditions of the female prisoners at Herstedvester Prison, the multi-annual agreement for 2008-2011 for the Prison and Probation Service allocated DKK 16 million for building improvements with a view to 'ensuring that female prisoners at Herstedvester Prison can be offered employment and leisure activities separate from the men and more opportunities to spend time with children and grandchildren'.

Subsequently, a new women's block was established at Herstedvester Prison:

- The block was moved and further rooms were included.
- A completely new section with three rooms with own bath and toilet was built.
- A new common room and a workshop were established.
- An interview room was created.
- The option of separate prison yard exercise in a separate outdoor area was introduced.
- A fitness training room was established.
- A washing machine and a tumble dryer were installed.
- Kitchen facilities were established.

In addition, two visitor flats were established, where the women can meet their families. These can also be used by other prisoners.

The new block etc. was inaugurated in late 2010.

AN ACTUAL WOMEN'S PRISON

The research project 'Perspectives on women's daily lives in Danish prisons' was completed in March 2011. In this connection, the Department of the Prison and Probation Service set up a committee with the task of making recommendations regarding the future housing of and offers for female prisoners. The

committee issued its recommendation on 12 September 2011. It recommended establishing an actual women's state prison in Denmark (with a closed block, a treatment block (psychiatric) and a medium- and a low-security block). The committee also recommended establishing three regional prison facilities for women.

Partly on the basis of the committee's work, the Parliamentary Ombudsman decided to pay particular attention to female prisoners in 2012. Thus, new inspections have been carried out at Horserød State Prison, Ringe State Prison and Herstedvester Prison, including the women's block. Møgelkær State Prison was inspected in 2010.

The Parliamentary Ombudsman will monitor further developments with regard to the possible establishment of an actual women's state prison as well as regional prison facilities for women.

As part of the Parliamentary Ombudsman's future inspection activities, it may be relevant to pay particular attention to the conditions of some of the other vulnerable groups or individuals mentioned at the start of this article.

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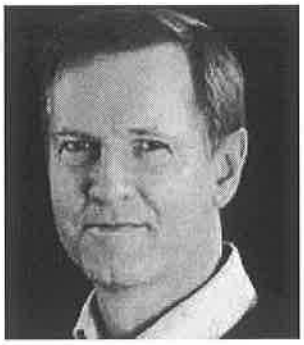
2014

TOLERATED RESIDENCE STATUS – BEHIND THE CASE



Morten Engberg
Senior Head of Department,
Monitoring Department

The Ombudsman carries out regular monitoring visits to institutions for detainees in order to ensure that they live under humane and dignified conditions. The target group includes, among others, prison inmates, patients at secure psychiatric wards and children placed in care.

Many monitoring visits are not carried out solely by the Ombudsman and his staff. The Ombudsman has a close cooperation with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights. Consequently, the two organisations often participate in monitoring visits.

Therefore, there was nothing unusual about the Ombudsman and representatives from the two organisations visiting the asylum centre 'Center Sandholm' in 2014 in order to look into conditions for persons under tolerated residence status. But the case touched on very sensitive and much discussed questions which would influence the Ombudsman's report.

Persons under tolerated residence status at 'Center Sandholm' are subject to a number of special restrictions. They are obligated to live at the centre (some of them in rooms together with one or two other people), they have a duty to report to the police (typically every day), they are not allowed to take on paid work, they receive a limited cash allowance (a maximum of DKK 31 a day), and in reality it is not possible for them to cook their own food; instead they get meal coupons for the centre's cafeteria.

There is no limitation to the duration of tolerated residence, and basically the tolerated residence may last indefinitely. Contrary to, for instance, the majority of prison inmates, it is thus not possible for persons under tolerated residence status to adjust to a situation which they know will last for a fixed period of time, and therefore they cannot look forward to a normalisation of their lives.

Statistics also confirm that tolerated residence can last for a very long time. In 2014, for instance, three persons living at 'Center Sandholm' had spent more than 10 years under tolerated residence status, and 12 persons had been under tolerated residence status for five to 10 years. Previously, only a few people were living under tolerated residence status in Denmark, but the number has increased in recent years. In 2002, 17 persons were living under tolerated residence status, whereas 67 persons were living under tolerated residence status in 2014.

The object of the monitoring visit was to get an impression of the conditions for persons under tolerated residence status and to assess whether these conditions are in conflict with, for instance, the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment or the European Convention on Human Rights. The purpose was also to assess whether the conditions are in conflict with the terms of the Ombudsman Act called 'universal human and humanitarian considerations'.

Who is living under tolerated residence status?

Persons under tolerated residence status live in Denmark even though they do not have the right to stay here. There are various reasons why they are not allowed to stay in Denmark: Some are excluded from obtaining asylum in Denmark because they have been deported and have been barred from entering the country due to crime committed in Denmark. There is also a group of people barred from obtaining asylum, for instance if there are serious reasons to believe that they have committed a grave, non-political crime abroad. Furthermore, there are a few people who live under tolerated residence status because they are considered a risk to state security.

The reason why these people live in Denmark is that it would be unlawful to deport them. They are covered by a provision in the Aliens Act according to which it is prohibited to deport people to another country where they risk the death penalty or risk being subjected to torture or inhuman or degrading treatment or punishment. According to this provision, it is also prohibited to deport people to a country where they are not protected against deportation to another country in which they may be exposed to such risks.

A LEGAL CHALLENGE

The investigation of the issue raised a number of legal issues. Firstly, we had to assess whether the conditions for persons under tolerated residence status at 'Center Sandholm' are in conflict with the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the

European Convention on Human Rights. The aforesaid conventions stipulate that no individual must be subjected to torture nor to inhuman or degrading treatment or punishment.

However, after having compared the general conditions at 'Center Sandholm' to the conventions we reached the conclusion that no conventions had been breached.

But, as mentioned before, our task was also to assess the conditions on the grounds of 'universal human and humanitarian considerations' pursuant to the Ombudsman Act. Naturally, this assessment has a wider scope than when the Ombudsman on a daily basis assesses for instance whether a ministry has given access to documents in accordance with the regulations.

The Ombudsman has assessed many previous cases on the basis of 'universal human and humanitarian considerations', but the conditions for persons under tolerated residence status at 'Center Sandholm' differ in several important aspects from our previous observations.

Therefore, we examined all the individual elements of the measure. We assessed how the measure affects persons under tolerated residence status in general. We also assessed the importance of the fact that the measure is of indefinite duration. In this connection, we noted that the Danish Red Cross, which is in charge of 'Center Sandholm', described common traits for persons under tolerated residence status in the form of, for instance, declining resources, abuse and isolation. And DIGNITY – Danish Institute Against Torture spoke of 'clear signs of severe mental stress' based on a medical assessment.

POLITICAL QUESTIONS

Another important consideration was that the conditions for persons under tolerated residence status are partly laid down in the Aliens Act. It is not the Ombudsman's task to take a position on, for instance, the reasonableness of legislation passed by Parliament, and we did not take a position in this case either. But on the other hand, we could not, as is our task pursuant to the Ombudsman Act, assess the conditions for persons under tolerated residence status without including the purpose of the legislation for this target group.

In his report, the Ombudsman pointed out that the group of persons under tolerated residence status is very complex. Therefore, the considerations behind the legislation take effect to a varying degree. One of the purposes of tolerated

residence is that it should be possible to find a person quickly if the person is to be deported. But if there is no prospect that the person can be deported from Denmark, this consideration must be of less importance than if a person comes from a country where there is a prospect of deportation. As another example, the Ombudsman pointed out that considerations in regard to national security and public order seem to be of varying importance, depending on whether the person in question is considered a risk to state security or has 'only' committed ordinary crime.

What did the Ombudsman say?

It was the Ombudsman's opinion that the overall conditions for people under tolerated residence status at 'Center Sandholm', compared to the indefinite duration aspect, were very stressful and restrictive for a normal life. However, the general conditions are not in conflict with the prohibition on, for instance, degrading treatment pursuant to the UN Convention against Torture and article 3 of the European Convention on Human Rights. Still, the Ombudsman could not rule out that the overall impact of the restrictions which people under tolerated residence status at 'Center Sandholm' face, might over time in specific cases result in what must be considered a violation of the conventions.

It was, however, also the Ombudsman's opinion that there is reason for the authorities to consider in more general terms to which extent, based on the regards behind the relevant legislation, it is necessary in all respects to maintain such overall stressful and restrictive living conditions as is currently the case. The Ombudsman's opinion was based on 'universal human and humanitarian considerations' which he must observe according to the Ombudsman Act.

(Annual Report 2014, Case No. 2014-42)

PARTNERS WITH DIFFERENT MANDATES

After the monitoring visit to 'Center Sandholm', we worked really hard to make the necessary assessments, but just as much to communicate the conclusions as precisely as possible to prevent misunderstandings.

During this process, it was an advantage for us that we could work together with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights. DIGNITY has a comprehensive medical knowledge and a detailed knowledge of the fight against torture, etc. while the Danish Institute for Human Rights has great expert knowledge within human rights legislation.

Denmark has acceded to the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,

which stipulates that each country must appoint a supervisory body in order to monitor that the convention against torture is not violated. In Denmark, this task is carried out by the Parliamentary Ombudsman in close cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

DIGNITY is a private non-governmental organisation with the aim of fighting torture, and the Danish Institute for Human Rights is a public organisation with the aim of promoting human rights. In our opinion, the cooperation has strengthened the Ombudsman's monitoring work because it has provided an opportunity to draw on expert knowledge in the two organisations.

THE OMBUDSMAN'S TASK

In his report, the Ombudsman wrote that 'there are grounds for a more general discussion of the extent to which – based on the regards behind the legislation, among other things – it is in all respects necessary to maintain such an overall stressful and restrictive way of life as is currently the case'.

It rarely happens that the Ombudsman in this way calls for a reconsideration of a measure that is partly stipulated by law. In addition to this, the case involves an issue which is much debated politically. But fundamentally, the Ombudsman only carried out the task as directed by the Ombudsman Act: to monitor the conditions of persons deprived of their liberty and to state his opinion on the matter.

FOLKETINGETS
OMBUDSMAND

Thematic Report on Addiction Treatment

Doc. No. 14/00877-8

What has the theme led to?

Addiction treatment was one of the themes for the monitoring visits which the Ombudsman carried out in institutions for adults in 2013 in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

On the basis of his monitoring visits, the Ombudsman generally recommends that accommodation facilities which provide alcohol and/or drug addiction treatment for adults and, as part of that treatment, use restrictive measures towards the addicts, make sure they enter into precise, written and voluntary agreements with each individual regarding which restrictions to be used towards him or her, prior to the person moving into the accommodation facility. The agreement should also state the possible consequences in case the resident breaches the agreement.

The Ombudsman will discuss the follow-up of this general recommendation with key authorities. In addition, he will follow up on the recommendation during his monitoring visits.

The Ombudsman has raised the question with the Department of the Prison and Probation Service whether the legal claim of treatment for drug addiction is respected when it comes to local prison inmates. He has also raised the question whether the treatment offered in local prisons only applies to inmates who speak Danish or possibly English.

The Ombudsman has discussed the issue of lack of continuity in addiction treatment in general with the Department of the Prison and Probation Service.

The Ombudsman has sent this report to the Department of the Prison and Probation Service, the Ministry of Health and Prevention, the Ministry of Children, Gender Equality, Integration and Social Affairs and to the National Board of Social Services. The purpose is to notify the authorities of the report so that the authorities can include it in their deliberations concerning this issue.

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

Reasons for the choice of theme

The Ombudsman addresses a number of general focus areas during his monitoring visits. Addiction treatment is part of the focus area on health factors.

The Social Services Act as well as the Health Act and the Sentence Enforcement Act hold guarantees on addiction treatment. According to the Social Services Act, the municipal authorities therefore have to offer treatment to substance abusers, and the offer has to be implemented no later than a fortnight after the treatment request to the municipality. Likewise, the municipal authorities offer free treatment to alcohol abusers in accordance with the Health Act. The treatment has to be started within a fortnight after the alcohol abuser has contacted the municipality and asked for treatment.

According to the Sentence Enforcement Act, inmates of the Prison and Probation Service's prisons and local prisons are entitled to free treatment for drug abuse unless the inmate is considered not suitable and motivated for treatment. To the extent possible, the drug abuse treatment has to be started within a fortnight after the inmate has asked the Prison and Probation Service for treatment.

The Act on Detention of Drug Abusers in Treatment gives on strict conditions access to the detention of drug abusers, and the Health Act also gives access – on strict conditions – to detain pregnant alcohol abusers. It was the Ombudsman's first impression that the Act on Detention of Drug Abusers in Treatment did not seem to be used in practice.

The Ombudsman's monitoring is particularly aimed at society's most vulnerable citizens. Some of the characteristics of the group of vulnerable citizens are that they usually have very few resources and that their rights may easily be put under pressure. This may also apply to substance abusers.

What did the Ombudsman do?

In 2013, the Ombudsman chose addiction treatment as one of the themes for his monitoring visits in institutions for adults. The theme was cross-sectional in the sense that addiction and addiction treatment were relevant in connection with the majority of the year's visits. The theme was relevant in relation to, for instance, prisons and psychiatric wards but also in connection with visits to accommodation facilities in the social services sector.

The theme had the following topics:

- The Ombudsman visited 13 accommodation facilities as part of the theme. 12 accommodation facilities treated addiction among adults (9 treated both alcohol and drug abuse, and 3 treated drug abuse only). The last accommodation facility was in the nature of a care centre especially for people who had been living with an addiction for many years and therefore had difficulties getting by in their own home.

- Prior to the monitoring visits, the Ombudsman asked the institution to explain to a relevant extent how the users' addiction treatment options were planned, including the number of users who had completed addiction treatment within the last three years.

- The talks which the Ombudsman's monitoring team had with management, staff, relatives and users at the facility in question also had addiction treatment as a focal point.

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

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

What did the Ombudsman find?

On the basis of the completed visits, the Ombudsman noted the following, among other things:

- Monitoring visits confirmed that the Act on Detention of Drug Abusers in Treatment does not seem used in practice.

- Monitoring visits in accommodation facilities for substance abusers showed that restrictions of various kinds towards the substance abusers were used in the accommodation facilities, and that in many cases this is based on a (form of) agreement between the accommodation facility and the substance abuser.

- Monitoring visits in local prisons showed that inmates are only offered so-called motivational therapy with actual addiction treatment in mind at a later stage. Several monitoring visits showed that the motivational therapy is only offered to inmates who speak Danish or English.

- The visiting teams observed potential problems in the Prison and Probation Service in the form of a lack of continuity in the addiction treatment at sector transfers, e.g. on release from prison.

- Many of the accommodation facilities for substance abusers would like information about recidivism.

The Act on Detention of Drug Abusers in Treatment and restrictions towards abusers

The monitoring visits confirmed that the Act on Detainment of Substance Abusers did not seem used in practice. The reason for the non-use of the Act seems to be the perception that addiction treatment ought to be voluntary and come into force through motivation. Thus, the substance abuser act is not used in practice at accommodation facilities.

During his monitoring visits at the 13 accommodation facilities for substance abusers, the Ombudsman found a number of different restrictions which the accommodation facilities implemented or could choose to implement in relation to the residents. The restrictions were generally introduced on treatment grounds. The purpose of a restriction could be, for example, to ensure that the substance abuser did not have access to alcohol or at least to limit that access.

The Ombudsman found the following restrictions, among others:

- Restrictions pertaining to freedom of mobility, for instance:
    - A rule that the resident when moving into the accommodation facility is always shielded which means that the resident is not allowed to leave the facility without being accompanied by staff. After 30 days of residency, the shielding is evaluated.
    - A rule that the resident must have been “clean” for four weeks before the first weekend at home.
    - A rule that the resident accepts restricted freedom of mobility, possibly a total curfew, if the staff assess that the resident’s sobriety (total abstinence from alcohol and other mood changing substances) is at risk and if other acute recidivism prevention plans do not seem useful.
    - A rule that the resident is not allowed to leave the facility on his or her own and always has to inform the staff.

- Inspection of the residents’ luggage and rooms, for instance:
    - A rule that the resident’s luggage is examined with the resident on arrival. Any medicines or things which the resident is not allowed to bring for the treatment will be looked after by management.
    - A rule that the resident has to keep his or her room clean and tidy and make the bed each morning. Regular inspections will take place.
    - A rule of an additional room inspection every Friday at noon.
    - A rule that if there is suspicion of illegal drug/alcohol possession, an inspection of the room will be carried out by at least two members of staff and the resident.

- Opening the residents’ incoming post, for instance:
    - A rule that parcels and letters have to be opened at the office so that the staff can see the content.
    - A rule that if money is sent (to the inmate), this must be handed over to the staff who make a note of the amount and place the money in a plastic sheet or the like at the office.

- Testing for intoxicants, for instance:
    - A rule that alcohol testing and urine testing will occur regularly without warning.
    - A rule that all residents must have their urine tested on arrival (the same day).
    - A rule that urine testing takes place under staff supervision.

- Restrictions on use of mobile phones and computers, for instance:
    - A rule that the mobile phone is only to be used in the resident's room and outdoors and has to be turned off everywhere else on the premises.
    - A rule that having a mobile phone is not allowed.
    - A rule that internet access is not allowed.
    - A rule that laptops are turned off at 11 pm every night by the staff.
    - A rule that laptops are allowed at the facility but that there are rules for their use, e.g. that laptops are not allowed in the residents' rooms.

- Restrictions in access to the media, for instance:
    - A rule that it is not allowed for the residents to bring a radio, CD player/walkman, computer, television or mobile phone into the facility. However, the resident is allowed to buy/read newspapers on Sundays.

The Act on Detainment of Substance Abusers in Treatment and the provisions in the Health Act about detaining pregnant alcohol abusers do not prevent the accommodation facility and the substance abuser from entering into individual agreements on rules for the stay at the facility and on demands and conditions for the substance abuser. It may be urine testing, alcohol testing and rules for release accompanied by staff in crisis situations, for example in connection with detoxing where there is a risk of recidivism.

Likewise, there is nothing to prevent an accommodation facility making a voluntary agreement with an individual resident about using certain restrictions as part of the addiction treatment, assuming it is clear to the resident which restrictions may be used towards him or her. The Ombudsman recommends that the facility enters into a written agreement prior to the resident moving into the facility.

The enforcement of an agreement between an accommodation facility and a resident – for example that the substance abuser cannot go on a trip out of the facility until he or she has been drug-free for 30 days – primarily has to be agreed upon by the facility and the resident. Therefore, it also has to be apparent from the agreement between the facility and the resident which consequences to expect if the resident breaches the agreement, for instance that the treatment may be stopped which in practice means that the stay at the accommodation facility has to come to an end.

At the same time, it is evident that an agreement between a facility and a resident cannot be enforced by e.g. physical force. This is because the conditions for using physical force in accordance with the rules that exist in this field, for instance in the Social Services Act, are not met in these situations.

Treatment guarantee for inmates in local prisons

According to the Sentence Enforcement Act and custody regulations, inmates in state and local prisons are entitled to free addiction treatment unless the inmate is assessed not suitable and motivated for treatment. This treatment guarantee not only applies to inmates serving long prison sentences. It also applies to inmates serving shorter sentences and for persons remanded in custody who are placed in local prisons – for a longer period of time in relatively many cases.

Monitoring visits to local prisons showed that, in practice, inmates in local prisons are offered addiction treatment that is intended – through individual or group therapy – to motivate the inmates to enter into proper treatment. Thus, the addiction treatment in local prisons resembles a so-called motivational therapy or pre-treatment. The question is whether this kind of treatment meets the requirements for addiction treatment according to the Sentence Enforcement Act and custody regulations.

The reason why other treatment is not offered in local prisons is due to practical problems in the local prisons, for instance that the individual local prison does not know for how long a person in remanded custody has to be imprisoned in the local prison. That makes it difficult to plan an actual treatment process.

Furthermore, several monitoring visits showed that the motivation treatment is offered solely to inmates who speak Danish or possibly English. The reason for this seems to be language barriers that were not easily removed, for instance by using an interpreter.

On that basis, the Ombudsman has decided to raise different issues with the Department of the Prison and Probation Service. The case is pending.

Continuity in addiction treatment in the Prison and Probation Service

In connection with the monitoring visits in 2013 in the Prison and Probation Service institutions, the Ombudsman received a long list of information about the addiction treatment in the institutions, including continuity of the treatment.

For instance, during a monitoring visit the Ombudsman was informed that there was focus on helping inmates with addiction problems continue their addiction treatment. During another monitoring visit, the Ombudsman was informed that many inmates dropped out of the treatment programme in connection with their release from prison. Dropping out could also happen because of transfer from local prison to state prison, because some inmates prioritised being closer to their families rather than serving time in a prison with addiction treatment or because inmates could not be in a treatment unit for security reasons.

Furthermore, there could be a shortage of space in the Prison and Probation Service's treatment units.

Inmates with addiction problems might also benefit from serving prison time in a drug-free ward but there were a shortage of space in such wards, and inmates could only apply for these wards on arrival to the prison, the Ombudsman was informed. One of the institutions said that transfer between institutions in general was a problem in relation to the different types of treatment.

The Ombudsman was also informed that the inmates by agreement with the addiction advisor were always able to continue the treatment on an outpatient basis if they were released from prison in the middle of a programme. The Ombudsman found that there were no statistics of what happened to the inmates after they were released from prison.

Moreover, in one institution the Ombudsman was informed that the therapists would typically not receive any information from any earlier therapists on the inmate's arrival. In another institution, it became clear that the institution disregarded an inmate's previous treatment prior to arrival so that a treatment already started could continue. Instead, the institution put more consideration into the inmate's treatment history in order to decide which treatment was of relevance to the inmate.

At the annual meeting in 2014, the Ombudsman discussed the general lack of continuity in addiction treatment with the Department of the Prison and Probation Service.

Information about recidivism

Many residential care facilities for substance abusers wanted information about the number of citizens nationwide who were drug-free after addiction treatment at the 24-hour facilities. The residential care facilities would also like information on how many of the drug-free citizens who continued being drug-free after e.g. one, two or five years and about which facility had the best recidivism statistics.

Copenhagen, 1 June 2015

FOLKETINGETS OMBUDSMAND

Themes for monitoring visits

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

The selection of a definite theme depends especially on where an additional monitoring effort is required. The Ombudsman often selects a narrow topic such as placement in solitary confinement cell under the Prison and Probation Service. At other times, the Ombudsman selects broad themes such as institutions for adults and treatment of alcohol and drug abuse.

The themes enable the Ombudsman to include current topics in the monitoring visits and to undertake an in-depth investigation of certain issues and to gain experience of practice, including best practice.

A principle aim of the carrying out of monitoring visits during that particular year is to clarify and investigate the themes of the year in question. In consequence of this, the main part of the annual monitoring visits are undertaken in institutions where the topics are relevant.

Thematic Reports

At the end of the year, the Ombudsman reports on the outcome of the monitoring visits during the year in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

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

General recommendations

The outcome of the themes may be general recommendations to the authorities such as, for example, a recommendation to draw up a policy for the prevention of inter-user violence and intimidation.

General recommendations are based on the Ombudsman's experience within the specific field. Such recommendations would normally be given to specific institutions during previous monitoring visits.

In general, the Ombudsman will discuss the follow-up on his general recommendations with key authorities. Furthermore, the Ombudsman will follow up on his recommendations during the monitoring visits.

The general recommendations are aimed at having a preventive effect. The reason for the preventive work within the monitoring area is based on the Ombudsman's task as National Preventive Mechanism pursuant to The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

The thematic reports are published on the Ombudsman's website www.ombudsmanden.dk. In addition to this, the Ombudsman also submits the reports to the relevant authorities so that the authorities can include the reports in their deliberations regarding the various sectors.

FOLKETINGETS OMBUDSMAND

Thematic Report on Prevention of Inter-user Violence and Intimidation

Doc. No. 14/01741-2

What has the theme led to?

The prevention of inter-user violence and intimidation was one of the themes for those monitoring visits which the Ombudsman carried out in institutions for adults in 2013 in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

On the basis of his monitoring visits, the Ombudsman generally recommends that institutions for adults, for instance prisons and accommodation facilities for adults, formulate a policy for prevention of inter-user violence and intimidation, unless this must be considered irrelevant in the specific institution.

A prevention policy may increase the focus on specific measures taken by each individual institution to prevent inter-user violence and intimidation. Consequently, such a policy may contribute to the prevention of inter-user violence and intimidation and the number of such incidents may be brought down and avoided to the largest possible extent.

The Ombudsman will discuss the follow-up on this general recommendation with key authorities. In addition, he will follow up on the recommendation during his monitoring visits.

The Ombudsman has compiled a list of actual initiatives and measures which he has encountered during his monitoring visits and which the institutions have used as part of their efforts to prevent inter-user violence and intimidation. The list includes for instance skills development and registration of inter-user violence and intimidation. The list may serve as inspiration for the institutions' efforts to prevent inter-user violence and intimidation, and it is included at the back of this report.

Both the formulation of a prevention policy and the list of initiatives and measures may be seen as part of the best practice for the prevention of inter-user violence and intimidation.

The formulation of a prevention policy is also in keeping with a recommendation made by the European Committee on the Prevention of Torture, etc. after a visit to Ringe State Prison in 2014. The Committee recommended that steps were taken to put into place a comprehensive anti-bullying strategy in order to reduce inter-prisoner violence and intimidation. In that context, the Committee also mentioned some of the initiatives and measures which are mentioned further down in this report.

The Ombudsman has sent this report to the Department of the Prison and Probation Service, the Ministry of Health and Prevention, the Ministry for Children, Gender Equality, Integration and Social Matters and to the National Board of Social Services. The purpose is to notify the authorities of the report so that the authorities can include it in their deliberations concerning this issue.

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

Reasons for the choice of theme

It is implied in human rights conventions that the State has a responsibility to protect prison inmates from abuse by other prisoners. In other words, the State shall protect persons deprived of their liberty from assault by other persons deprived of their liberty.

The Ombudsman addresses a number of general focus areas during his monitoring visits. Prevention of inter-user violence and intimidation is part of the focus area of interactions which deals with the relationship between users, among other things.

The Ombudsman's monitoring is particularly aimed at society's most vulnerable citizens. Some of the characteristics of the group of vulnerable citizens are that they usually have very few resources and that their rights may easily be put under pressure. This may also apply to citizens who are deprived of their liberty.

What did the Ombudsman do?

In 2013, the Ombudsman chose prevention of inter-user violence and intimidation as one of the themes for his monitoring visits to institutions for adults. The theme was cross-sectional in the sense that prevention of inter-user violence and intimidation was relevant in connection with the majority of the visits that year. The theme was relevant in relation to, for instance, visits to prisons and psychiatric wards but also in connection with visits to accommodation facilities in the social services sector.

The theme had the following topics:

- The Ombudsman asked the institution to provide advance information to a relevant extent on the way in which the institution prevented inter-user violence and intimidation

- The talks which the Ombudsman's monitoring team had with the management, staff, relatives and users in the institution were also focused on the prevention of inter-user violence and intimidation.

In addition, the Ombudsman asked the institution to inform him in advance of the number of episodes involving inter-user violence and intimidation within the last three years and of the guidelines for the handling of violent incidents (anti-violence policy).

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

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

What did the Ombudsman find?

On the basis of the completed visits, the Ombudsman noted the following, among other things:

- Many institutions were conscious of the need to prevent inter-user violence and intimidation and they implemented various initiatives and measures as part of their prevention efforts.

- Most institutions had not formulated a policy on the prevention of inter-user violence and intimidation. On the other hand, the institutions had often

formulated a policy regarding violence and threats against staff (work environment perspective).

List of initiatives and measures to prevent inter-user violence and intimidation

The Ombudsman has compiled a list of some of the various specific initiatives and measures which he encountered during the monitoring visits and which the institutions used as part of their efforts to prevent inter-user violence and intimidation. The list may serve as inspiration for the institutions' efforts to prevent inter-user violence and intimidation.

Please note that the list is not exhaustive. In addition, the list includes in particular initiatives and measures tied to human relationships between users themselves and between users and staff, just as the list shows that the setting of values is used in the institutions to prevent inter-user violence and intimidation. Many other measures may be worth considering, for instance the use of a special admission unit, closed cell doors, sectioning, transfer of users and interior decorating initiatives, perhaps with regard to choice of colour.

Finally, please note that the Ombudsman has not assessed the effect of the various initiatives and measures he has seen used. This is because the Ombudsman does not have the qualifications for making such an assessment.

See the list overleaf.

Copenhagen, 1 June 2015

List of initiatives and measures aimed at preventing inter-user violence and intimidation

1. Continuous skills development of staff, for instance through courses on conflict management or prevention of violence, and follow-up courses.

2. Establishing a set of values in the institution, consisting of for instance integrity, recognition and dialogue, and to verbalise these values on the user's arrival at the institution.

3. Induction programme on arrival during which it is agreed with the user how the staff may help in a conflict situation, including the way in which the user would prefer to be confronted when behaving inappropriately towards fellow users.

4. Risk assessment of the user on arrival and then on a regular basis.

5. According to the house rules, violence and intimidation will not be tolerated in any way, and the user signs the house rules, stating that he/she has read them and will abide by them.

6. Staff are focused on dialogue, take the user seriously and meet the user with attention and solicitude.

7. Staff are accessible to the users and observant of the moods among the institution's users.

8. The staff are focused on creating the framework for a good community spirit between the users and assess the users' ability to be a part of the community and their need for support, attitude adjustment and normal role models.

9. Management are focused on creating good relations between the users through accessible management, attitude adjustment, showing respect for the users and observing a good level of information.

10. Focus on continuously integrating the violence and intimidation preventing efforts into the pedagogical practice.

11. Staff endeavour to provide the user with alternative options for solving conflicts, both as role models and through guidance, and to discover why the user reacted with violence and intimidation in a particular situation.

12. Registration of, and follow-up on, inter-user violence and intimidation with a view to record-keeping, insight and learning.

13. Staff react consistently, act and follow up on violence and intimidation, for instance by helping the user to report the violence to the police.

14. Dialogue between users via conflict councils when conflicts do occur.

ENCLOSURE

THEMES – ADULTS

FOLKETINGETS OMBUDSMAND

Themes for monitoring visits

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

The selection of a definite theme depends especially on where an additional monitoring effort is required. The Ombudsman often selects a narrow topic such as placement in solitary confinement cell under the Prison and Probation Service. At other times, the Ombudsman selects broad themes such as institutions for adults and treatment of alcohol and drug abuse.

The themes enable the Ombudsman to include current topics in the monitoring visits and to undertake an in-depth investigation of certain issues and to gain experience of practice, including best practice.

A principle aim of the carrying out of monitoring visits during that particular year is to clarify and investigate the themes of the year in question. In consequence of this, the main part of the annual monitoring visits are undertaken in institutions where the topics are relevant.

Thematic Reports

At the end of the year, the Ombudsman reports on the outcome of the monitoring visits during the year in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

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

General recommendations

The outcome of the themes may be general recommendations to the authorities such as, for example, a recommendation to draw up a policy for the prevention of inter-user violence and intimidation.

General recommendations are based on the Ombudsman's experience within the specific field. Such recommendations would normally be given to specific institutions during previous monitoring visits.

In general, the Ombudsman will discuss the follow-up on his general recommendations with key authorities. Furthermore, the Ombudsman will follow up on his recommendations during the monitoring visits.

The general recommendations are aimed at having a preventive effect. The reason for the preventive work within the monitoring area is based on the Ombudsman's task as National Preventive Mechanism pursuant to The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

The thematic reports are published on the Ombudsman's website www.ombudsmanden.dk. In addition to this, the Ombudsman also submits the reports to the relevant authorities so that the authorities can include the reports in their deliberations regarding the various sectors.

FOLKETINGETS
OMBUDSMAND

Thematic Report on Prevention of Suicide and Suicide Attempts

Doc. No. 14/03194-2

What has the theme led to?

Prevention of suicides and suicide attempts was one of the themes for the monitoring visits which the Ombudsman carried out in institutions for adults in 2014 in cooperation with the Danish Institute for Human Rights (IMR) and DIGNITY – Danish Institute Against Torture.

The Ombudsman's overall impression was that the institutions were generally conscious of the need to prevent suicides and suicide attempts.

The Ombudsman has discussed the issue of general guidelines for the suicide risk screening carried out by prison staff within the Department of the Prison and Probation Service. In addition, the Ombudsman has recommended that the Department considers introducing guidelines for the prison staff's monitoring of suicidal inmates.

The Ombudsman has sent this report to the Department of the Prison and Probation Service, the Ministry of Health and Prevention, the Ministry for Children, Gender Equality, Integration and Social Matters and to the National Board of Social Services. The purpose is to notify the authorities of the report so that the authorities can include it in their deliberations concerning this issue.

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

Reasons for the choice of theme

The Ombudsman has a number of general focus areas during his monitoring visits. Prevention of suicide and suicide attempts is part of the general focus area regarding health-related matters.

According to an agreement with the Department of the Prison and Probation Service, the Ombudsman has for a number of years been apprised of incidents which have been reported according to the rules on reporting deaths, including suicide, and suicide attempts among inmates in the prison service institutions. The rules now appear from the Department's circular on the institution's treatment and reporting of incidents involving death, suicide, suicide attempt and other suicidal or self-harming behaviour among inmates in the care of the prison service.

When for instance a suicide takes place in a prison service institution, the institution will investigate the incident and send a detailed report to the Department of the Prison and Probation Service which will then make a decision in the case. The Department sends its decision and the case documents to the Ombudsman for assessment.

Similar arrangements have been agreed with the Ministry of Justice in relation to incidents in police holding cells and with Region Zealand with regard to incidents at the secure forensic psychiatric hospital at Nykøbing Sjælland.

With this theme the Ombudsman particularly wished to examine the measures taken to prevent incidents involving suicide and suicide attempts by institutions in other sectors, for instance by accommodation facilities and psychiatric wards.

The Ombudsman's monitoring is particularly aimed at society's most vulnerable citizens. Some of the characteristics of the group of vulnerable citizens are that they usually have very few resources and that their rights may easily be put under pressure. This may also apply to people who are at risk of committing suicide.

What did the Ombudsman do?

In 2014, the Ombudsman chose prevention of suicide and suicide attempts as one of the themes for his monitoring visits to institutions for adults. The theme was cross-sectional, in the sense that prevention of suicide and suicide attempts was relevant in connection with the majority of the visits that year. Consequently, the theme was relevant in connection with visits to local prisons and psychiatric wards but also in connection with visits to for instance accommodation facilities in the social services sector.

The theme included the following topics:

- The Ombudsman asked the institution to provide advance information to a relevant extent on the following:
    - Written material on prevention of and follow-up on suicide and suicide attempts, including any instructions with practical directions for the institution's handling of a person who is or may be suicidal.
    - Number of suicides and suicide attempts within the last three years.

  - Supplementary training of staff in preventing and following up on suicide and suicide attempts.
  - Procedure for screening of whether or not a person is suicidal.

- In addition, the Ombudsman asked the institution to account in advance for the following, when relevant:
  - How does the institution prevent suicide and suicide attempts?
  - How does the institution handle groups which may be at special risk of (attempting) suicide, for instance new inmates/newly hospitalised patients, newly discharged psychiatric patients and persons who have previously attempted suicide?
  - How does the institution handle groups which may present special difficulties in assessing whether they are suicidal (for instance psychotic users, safeguarded users, users with a non-Danish ethnic background and users who do not speak Danish)?

- The talks which the Ombudsman's monitoring team had with the management, staff, relatives and users at the institution were also focused on the prevention of suicide and suicide attempts.

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

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 Human Rights Institute and DIGNITY contribute to the cooperation with special medical and human rights expertise, meaning that staff with this expertise participates in the planning and execution of and follow-up on monitoring visits on behalf of the two institutes.

What did the Ombudsman find?

On the basis of the completed visits, the Ombudsman noted the following, among other things:

- Psychiatric wards had screening procedures and written instructions, etc. on for instance prevention and suicide risk assessment. Several wards provided relevant supplementary training for staff and some wards were planning to have supplementary training.

- Accommodation facilities did not have written material, screening procedures or supplementary training.

- There were differences between the prison service institutions regarding written material, screening and supplementary training.

- The Ombudsman's overall impression was that the institutions were generally conscious of the need to prevent suicide and suicide attempts.

Recommendations

The 2014 monitoring visits provided the Ombudsman with a long range of data on the prevention of suicide and suicide attempts in the institutions.

The information gave the Ombudsman's monitoring teams cause to make various recommendations.

For instance, it was recommended to some institutions that they draw up a set of guidelines on how to prevent suicide and suicide attempts. It has also been recommended that guidelines be drawn up on screening for suicidal behaviour.

Prior to a monitoring visit to one of the prison service institutions, the Ombudsman received the guidelines for suicide risk assessment by the healthcare staff. The prison staff assessed the suicide risk until the healthcare staff were able to assess the inmate. As the prison staff were not healthcare professionals, and as there were no guidelines for the prison staff's assessment, it could be difficult for the prison staff to carry out a professionally safe assessment.

The Ombudsman's monitoring team therefore recommended adding guidelines for the suicide risk assessment carried out by the prison staff and other staff groups.

At the annual meeting in 2015, the Ombudsman and the Department of the Prison and Probation Service discussed the issue of general guidelines for suicide risk screening carried out by particularly other staff groups than healthcare professionals. The Department stated that admission units have been established in all prisons where newly arrived inmates are screened for the risk of suicide. The case regarding general guidelines is pending.

The issue of fixed guidelines for the observation by prison staff of suicidal inmates was discussed with the Department of the Prison and Probation Service at the annual meeting in 2014. In this context, the Ombudsman recommended that the Department consider establishing guidelines for monitoring at fixed intervals.

At the meeting in 2015, the Department stated that the work of writing such standards was in motion. The case is pending.

Copenhagen, 1 June 2015

FOLKETINGETS OMBUDSMAND

Themes for monitoring visits

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

The selection of a definite theme depends especially on where an additional monitoring effort is required. The Ombudsman often selects a narrow topic such as placement in solitary confinement cell under the Prison and Probation Service. At other times, the Ombudsman selects broad themes such as institutions for adults and treatment of alcohol and drug abuse.

The themes enable the Ombudsman to include current topics in the monitoring visits and to undertake an in-depth investigation of certain issues and to gain experience of practice, including best practice.

A principle aim of the carrying out of monitoring visits during that particular year is to clarify and investigate the themes of the year in question. In consequence of this, the main part of the annual monitoring visits are undertaken in institutions where the topics are relevant.

Thematic Reports

At the end of the year, the Ombudsman reports on the outcome of the monitoring visits during the year in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

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

General recommendations

The outcome of the themes may be general recommendations to the authorities such as, for example, a recommendation to draw up a policy for the prevention of inter-user violence and intimidation.

General recommendations are based on the Ombudsman's experience within the specific field. Such recommendations would normally be given to specific institutions during previous monitoring visits.

In general, the Ombudsman will discuss the follow-up on his general recommendations with key authorities. Furthermore, the Ombudsman will follow up on his recommendations during the monitoring visits.

The general recommendations are aimed at having a preventive effect. The reason for the preventive work within the monitoring area is based on the Ombudsman's task as National Preventive Mechanism pursuant to The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

The thematic reports are published on the Ombudsman's website www.ombudsmanden.dk. In addition to this, the Ombudsman also submits the reports to the relevant authorities so that the authorities can include the reports in their deliberations regarding the various sectors.

FOLKETINGETS
OMBUDSMAND

Thematic Report on Psychiatry

Doc. No. 14/01062-3

What has the theme led to?

Psychiatry was one of the themes for the monitoring visits in 2014 carried out by the Ombudsman in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

On the basis of his monitoring visits, the Ombudsman generally recommends that psychiatric wards continuously prepare and make active use of statistics on the use of force at unit level. The purpose of carrying out this statistical control of the use of force is to provide the institution management with information about patterns in and reasons for forcible measures undertaken in order to prevent and reduce forcible measures as much as possible.

The Ombudsman will discuss the follow-up on this general recommendation with key authorities. In addition, the Ombudsman will follow up on the issue during his monitoring visits.

The Ombudsman will discuss with the Ministry of Health the differences in the wards' possibilities of statistical control of data as regards the use of force.

The Ombudsman has asked the Ministry of Health whether it would be advisable to lay down guidelines for recommended standard house rules for psychiatric wards.

The Ombudsman has passed on information from psychiatric wards to the Ministry of Health about lack of feedback from the Danish Health and Medicines Authority on reports of the use of forcible measures.

The Ombudsman will discuss with the Ministry of Health the issue of enforcement of telephone restrictions at psychiatric wards where patients with and without such restriction are hospitalised.

The Ombudsman has sent this report to the Ministry of Health and to the Mental Health Services of the Regions of Southern Denmark, Central Denmark, North Denmark, Zealand, 'The Psychiatric House' (Psykiatrihuset) and the Capital Region of Denmark. The purpose is to notify the authorities of the report so that the authorities can include it in their deliberations concerning this issue.

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

Reasons for the choice of theme

By selecting the psychiatry theme, the Ombudsman wanted to check up on the conditions at institutions for adults within these areas:

- Conditions for patients with disorders relating to forensic psychiatry.
- Forced physical restraint within the psychiatric sector.
- Access to psychiatric wards.
- Activities for users with a psychiatric disorder.

The Ombudsman selects a number of general topics during his monitoring visits. For example, forcible measures and other restrictions, disciplinary measures and informal initiatives are included in the Ombudsman's general focus points during his monitoring visits.

The theme was selected in order to give the Ombudsman an increased insight into and to assess the conditions for forensic psychiatric patients during their hospitalisation, including forensic psychiatric wards. The Ombudsman was paying particular attention to the use of force, restrictions and limitations as regards the patients' rights at forensic psychiatric wards as well as ordinary wards.

In spite of ambitions of the opposite, the number of persons who were forcefully restrained rose from 2010 till 2012. The assessment of the Danish State Serum Institute on forcible measures within psychiatry from 2001-2013 shows that the number of immobilised persons was rising during 2010-2012 (1831 persons were immobilised in 2010, 1981 persons in 2011 and 1993 persons in 2012). Moreover, it also appears from the assessment that the increase continued in 2013 when 2084 persons were immobilised.

The coercive nature of the forcible restraint for the individual patient is emphasised in a judgment by the High Court of Eastern Denmark of 8 July 2014 (U2014.3300Ø) according to which unjustified immobilisation during admission to a forensic psychiatric unit must be considered as resulting in such intense physical and mental suffering that the restraint violates Article 3 of the European Convention on Human Rights. Article 3 prohibits torture and inhuman or degrading treatment or punishment.

The Ombudsman is also giving general priority to work and leisure time activities as far as the users' access to activities are concerned. Transfers between different sectors, for example discharge from a psychiatric ward to a private accommodation facility, is also one of the Ombudsman's overall focus points.

During his monitoring visits, the Ombudsman requested, among other things, information within these focus areas as to which extent users with a psychiatric disorder made use of the activities offered and how accommodation facilities experienced the residents' access to a psychiatric ward. The reason for asking these questions was that the Ombudsman during previous monitoring visits had been told that there may be problems within these areas.

The Ombudsman's monitoring is particularly aimed at society's most vulnerable citizens. Some of the characteristics of the group of vulnerable citizens are that they usually have very few resources and that their rights may easily be put under pressure. This may also apply to users with a psychiatric disorder, including patients at a psychiatric ward.

What did the Ombudsman do?

In 2014, the Ombudsman selected psychiatry as one of the themes for his monitoring visits to institutions for adults. The theme was cross-sectional in the sense that conditions for users with a psychiatric disorder was relevant as regards the main part of the visits during the year. The theme was not only of interest when visiting psychiatric wards, but also when visiting accommodation facilities within the social sector as well as prisons.

The theme was divided into these topics:

- Conditions for forensic psychiatric patients:
    - In this context, the Ombudsman visited 10 general psychiatric units which often also included forensic psychiatric patients, and 21 units for forensic psychiatric patients only.
    - The Ombudsman asked the general psychiatric ward to provide him with information beforehand about
        - number of forensic psychiatric patients placed at an ordinary psychiatric ward within the last three years.
        - who made the decision to place a forensic psychiatric patient at a general psychiatric ward, and the criteria for reaching this decision.
        - how were staff members prepared for handling forensic psychiatric patients at an ordinary psychiatric ward.

- The Ombudsman also asked the general psychiatric ward to state beforehand
  - whether the question of placing forensic psychiatric patients at a general psychiatric ward together with non-forensic psychiatric patients had been considered, including information about these deliberations.
  - possible consequences of placing forensic psychiatric patients together with non-forensic psychiatric patients, and numerical data which could clarify same (for example, increased use of force, increased number of removals from forensic psychiatric wards as well as satisfaction surveys).

- Forced immobilisation within psychiatry:
  - The Ombudsman visited 31 psychiatric units, including forensic psychiatric units.
  - The Ombudsman asked the psychiatric ward to provide him beforehand with the 3 latest cases on forced immobilisation at each unit (entries in coercive measures protocol and report of the follow-up sessions).
  - In connection with the cases on forced immobilisation, the Ombudsman asked the ward to state beforehand which information the institution management had received about these restraints, and whether the institution management had carried out an analysis of the restraints and subsequently implemented initiatives to prevent forced immobilisation and, if so, which type of initiative.
  - Prior to the visit, the Ombudsman's visiting team examined the cases about restraint based on a form focusing on whether essential selected procedure rules had been observed. The form is enclosed.
  - The Ombudsman investigated 54 entries in coercive measures protocols as regards restraint and reports, if any, of the subsequent follow-up session which had been undertaken after termination of the restraint.

- Access to psychiatric ward:
  - The Ombudsman requested relevant information beforehand about
    - for example, how had the accommodation facility experienced the residents' access to admission at a psychiatric ward within the last year.

        - whether it had become necessary for the psychiatric ward within the last year to reject citizens for other than medical reasons, for example due to capacity or security reasons.

- Activities for users with a psychiatric disorder:
    - The Ombudsman asked the institution to provide him with information beforehand about
        - the extent to which users with a psychiatric disorder made use of the individual offers of activity.
        - users, by name, who did not make use of or hardly ever made use of the activities offered.
        - how the institution motivated users who did not or hardly ever made use of the activities offered.

- The talks of the Ombudsman's team with the institution's management, staff, relatives and users also focused on the mentioned conditions within psychiatry.

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

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

What did the Ombudsman find?

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

- An overall impression that placement of forensic psychiatric patients at general psychiatric wards does not normally give rise to special difficulties for the wards. It could, however, be difficult for psychiatric wards, including forensic psychiatric wards, to maintain control of the patients' use of telephone when the ward comprised patients both with and without such restriction.

- The Ombudsman noticed that the contents of the wards' house rules varied significantly and that the authority for several of the rules could be in doubt. Furthermore, in many cases the house rules did not state the consequences of breaking the house rules.

- There was a difference in the individual wards' possibilities of statistically monitoring the use of force to find possible connections and patterns as well as reasons for the force used towards the patients.

- The investigation of cases regarding forced immobilisation showed that the wards had a number of difficulties within the field, especially regarding obligatory investigation of the use of restraint and the completion of subsequent sessions.

- The Ombudsman was informed that psychiatric wards did not receive any feedback from the Danish Health and Medicines Authority on the reports regarding coercive measures which the wards had sent to the Authority.

Forensic psychiatric patients in general psychiatric wards

A number of psychiatric wards stated that placement of forensic psychiatric patients did not generally give rise to special difficulties for the wards. This was because forensic psychiatric patients were patients with a psychiatric disorder just like the other hospitalised patients and that possible problems depended on the individual patient. One ward stated that forensic psychiatric patients affected the wards' atmosphere.

For the sake of the objective of the remand, the police can oppose that a remand prisoner has telephone conversations. Forensic psychiatric patients with another non-custodial sentence may also be subject to telephone restrictions.

The monitoring visits to psychiatric wards indicated that it can be difficult for the wards to uphold the telephone restrictions in cases where a forensic psychiatric patient with

telephone restrictions is hospitalised together with patients without such restrictions at a psychiatric ward, including a forensic psychiatric ward, to which forensic psychiatric patients are also admitted.

The difficulties may vary. Some psychiatric wards were unable to ensure enforcement of telephone restrictions.

One ward stated, for example, that the ward checked whether remanded patients borrowed other patients' mobile phones. At the same time, the ward assumed that this happened. Another ward informed us that it commonly occurred that remanded patients threatened other patients into lending them their phones. The ward informed the police that the ward was unable to ensure that telephone restrictions for remanded patients were enforced. In order to ensure that such restrictions were enforced, the patients in question would need to be transferred to a proper forensic psychiatric ward.

A third ward informed the Ombudsman that difficulties may arise as regards forensic psychiatric patients' access to various means of communication since many of these patients were subject to telephone, visit and internet restrictions whereas ordinary patients had access to same. It could be difficult for the staff to enforce this and required close attention on the forensic psychiatric patients.

Other wards enforced telephone restrictions by simultaneous restrictions on other patients who were not subjected to such restrictions.

Accordingly, the Ombudsman was informed during a visit that forensic psychiatric patients with telephone restrictions resulted in restrictions also on forensic psychiatric patients without such restrictions as regards, for example, the use of a mobile phone. A ward stated that mobile phones were always confiscated from the patients because the ward's patients always included patients subject to telephone restriction. Patients without telephone restrictions could ask for permission to make a phone call by using a mobile phone in the visiting room. These patients were also allowed to use the ward's coin-operated telephone.

The Ombudsman will discuss the issue of enforcement of telephone restrictions with the Ministry of Health.

House rules at psychiatric wards

Pursuant to the Danish Mental Health Act, written house rules must be available to the patients at every psychiatric ward. The house rules must be handed out to the patient upon admission.

Prior to his monitoring visit to a psychiatric ward, the Ombudsman requests a copy of the house rules of the units he visits.

House rules must contain general rules regarding the patients' opportunities for activities during admission such as, for example, rules of access to making phone calls and permission to receive visits.

The monitoring visits to psychiatric wards indicated that the contents of the wards' house rules varied greatly, and that doubt might arise as regards the authority for some of the rules.

The Ombudsman received information about examples of various house rules which included the following, among other things:

- On admission all patients are body-searched and in cooperation with the patient, the staff checks the luggage brought along.

- On admission or transfer to the unit, belongings are checked and a possible body search is carried out in order to remove objects which may harm the patient or others. The confiscated objects are kept in a locked safe and will be returned upon discharge or transfer.

- As a main rule, patients have access to the computers available at the communal areas. A private computer requires permission by the unit management and it must not be possible to link up the computer to a network.

- Visits to the unit must be planned so that the staff are informed about the visit the day before. Visits take place in the purpose-built visiting rooms. All visits will be supervised for security reasons. Objects that visitors wish to bring into the unit will be checked.

- The following objects, among other things, must not be taken into, brought along to and are not allowed in the unit:
    - Mobile phones.
    - Money.
    - Letters to or from the patient or fellow patients.

- Incoming parcels and mail are opened by the staff together with the patient. However, this does not apply to mail from a public authority. If the patient opposes these guidelines, the parcel/letter will not be handed out.

- Patients with telephone restrictions are only allowed to make phone calls to public authorities. Other patients are allowed to make one phone call during day shift and one phone call during evening shift. The patient pays for the phone calls himself. The phone call must not last longer than 10 minutes. If the connection fails upon the first call, an extra call is allowed. After this, the patient is not allowed to make further phone calls during this shift. If patients have no money in the bank, no phone calls are allowed. Phone calls to lawyer, patient counsellor or social security guardian are free of charge. Incoming calls are accepted without limitation, but regards for other patients must be taken. In case of misuse, the arrangement can be made more strict/cancelled. Likewise, a limitation of calls may be imposed for treatment purposes.

- For security reasons patients are not allowed to stay in other patients' rooms.

The received house rules gave rise to various recommendations.

The Ombudsman recommended, for example, that the management upon a review of the house rules was aware of not imposing restrictions without the requisite authorisation.

One visiting team pointed out that similar conditions were described differently in house rules of the various units at the same psychiatric ward. The visiting team recommended that the management considers standardisation of the contents of the house rules. Some of the wards had started working on harmonising the house rules.

House rules must also include general rules of the consequences of non-compliance with the house rules.

During most of his monitoring visits in 2014, the Ombudsman's visiting team found that the house rules did not state the consequences of non-compliance with the house rules. Consequently, the visiting team recommended in many cases that the wards ensure that these consequences were stated in the house rules.

The review of the house rules and the discussions during the monitoring visits led to the Ombudsman asking the Ministry of Health during his annual meeting with the Ministry whether it would be appropriate to prepare instructions for standard house rules. The Ministry will consider the matter.

The wards' possibility of statistically supervising the use of force

In connection with his monitoring visits to psychiatric wards in 2014, the Ombudsman was provided with a wide range of information about the use of force at the various wards. The Ombudsman was, among other things, informed of how the wards carried out statistical supervision of the use of force.

Data on the use of force enable the wards to identify possible connections, patterns in and reasons for the coercive measures towards the patients. The wards can make use of this knowledge in order to systematically reducing the use of force. In this way, the wards are able to statistically supervising the use of force and act to a relevant extent.

Therefore, the Ombudsman recommends that psychiatric wards prepare and make active use of statistics about the use of force at unit level on a continuous basis. The purpose of doing so is aimed at providing the management with information about possible patterns in and reasons for the coercive measures exercised in order to prevent and reduce coercive measures as much as possible.

The monitoring visits showed that there is a difference as regards which possibilities the individual wards have as to statistical supervision of the use of force, and how these possibilities are used.

It was, for example, impossible for one ward to collect statistical data on the use of force at unit level whereas other wards were given this possibility. The ward – without this possibility – stated that the ward would probably be able to collect statistical data at unit level approx. 3 months later.

One ward stated that it was not possible for the management to extract figures as to duration of belt fixation. The units themselves were also unable to prepare systematic surveys of the use of force divided into type, times, staff, etc. However, these figures could be provided by the Region. A project enabling the units themselves to prepare figures for an analysis of possible causal connections was on the way. It had not until recently become possible for the ward to collect individual figures on the use of force at the individual units from the Region. Another ward stated that statistics were prepared centrally and that it was an unresolved task of the individual units to make more systematic use hereof.

A number of wards were able to extract various statistics on the use of force at unit level.

Some of the wards were able to link statistics on the use of force together with statistics within other fields.

As an example, one ward's database system made it possible to combine data on the use of force with data on, among other things, absence due to illness, medicine management (both at unit level and for the individual patient) together with patient aggression measurements. The patient aggression measurements provided detailed information about date, time of day and type of aggression, whereas data on the use of force showed date and time of the day. Thus, possible causal connections were clarified this way.

Another ward used statistics showing times during the day or week when there was a more frequent use of fixation and whether coercive measures were linked to less experienced staff.

During a monitoring visit, the management stated that it was impossible to extract statistics as regards the extent to which the staff (specified by name) had participated in the coercive measures undertaken.

The visiting teams gave various recommendations to the wards regarding statistical supervision of the use of force.

For example, a visiting team recommended to a ward to keep statistics on the use of force, also at unit level, with statement of time, enabling an analysis of possible patterns in the use of force.

It was also recommended that a ward continued to work on accessing data on the use of force, thus enabling the management to make analyses to detect possible patterns in order to improve prevention of the use of force.

During a monitoring visit, a visiting team emphasised that analyses and supervision of the use of force should be based on a secure statistical foundation and not on intuition.

The Ombudsman will discuss with the Ministry of Health the differences in the wards' ability to supervise the use of force.

Cases about forced immobilisation

A patient admitted to a psychiatric ward can be forcefully restrained pursuant to the Danish Mental Health Act.

Forced immobilisation may only be used when deemed necessary in order to prevent the patient from exposing himself or others to possible danger of harming body or health, to prevent the patient from persecuting or in any other way grossly abusing other patients or committing acts of vandalism to a not inconsiderable extent. Furthermore, a patient who for safety reasons asks for physical restraint will be restrained if a physician consents. The psychiatric ward is only allowed to use belt, hand and foot straps as well as gloves to immobilise the patient.

The Danish Mental Health Act stipulates a number of procedural rules which must be observed when a patient is physically restrained. The rules include special legal rights guarantees. The Danish Mental Health Act has been changed in some respects. As an example, the rules have been changed with regard to the minimum required frequency of a renewed medical assessment. The changes come into force as of 1 June 2015.

All psychiatric wards must have a coercive measures protocol. The ward's staff must enter the use of physical restraint in the protocol in accordance with the rules regarding which information the staff must enter in the protocol.

The Ombudsman examined 54 entries in the coercive measures protocol such as fixation on the basis of the form enclosed with this report. The visiting teams informed

the various wards about the outcome of the examination to a relevant extent and provided relevant recommendations.

The consultant psychiatrist is responsible for forced immobilisation not being used to a further extent than necessary. Moreover, the Danish Mental Health Act foresees that forced immobilisation must be reassessed at set intervals. Thus, if a patient must continue to be restrained as often as conditions necessitate it, a new medical assessment must be undertaken, however at least 4 times a day. The 4 times must be undertaken regularly after a decision on forced immobilisation has been made. The date for the new medical assessment must appear from the coercive measures protocol.

The examination of the entries in the coercive measures protocols indicated, among other things, that in a number of cases it did not appear from the coercive measures protocol that a new medical assessment had been undertaken evenly 4 times a day as to whether the patient should continue to be physically restrained.

As an example, according to a coercive measures protocol a patient was physically restrained with a restraint belt from 28 August 2013 at 23.15 pm until 29 August 2013 at 12.45 pm without a new medical assessment. Another example from the protocol showed that a patient fixated with a restraint belt was medically assessed on 25 September 2013 at 10.00 am, and that the next medical assessment was undertaken on 26 September 2013 at 10.00 am.

The management of the ward informed the visiting team that the management would raise the issue at once and impress the rules on the staff. Furthermore, the management intended in future to include measures of rule compliance in the coercive measures protocols in the management information system.

If a forced immobilisation lasts longer than 48 hours, an external physician must assess whether the patient must continue to be physically restrained. That the physician is external means that he or she is not employed by the psychiatric unit where the physical restraint takes place, that he or she is not responsible for the patient’s treatment and that he or she is not a subordinate to the physician in charge of the patient’s treatment. The external physician must be a specialist consultant in psychiatry. Should disagreement between the external physician and the physician in charge of the patient’s treatment arise, the assessment of the physician in charge of the patient’s treatment will be decisive.

Subsequently, the external medical assessment must be repeated once a week as long as the patient is physically restrained. Time of the external medical assessment must be entered in the coercive measures protocol. The consultant physician must immediately after expiration of the 48 hours and after the expiration of the subsequent periods of 7 days ensure that an external physician is called in to make the assessment.

The examination of the coercive measures protocols showed, among other things, that on a few occasions the external medical assessment had not been stated in the coercive measures protocol.

In one case, a forced immobilisation lasted 92 days, 21 hours and 15 minutes from 6 January 2014, 14.15 pm until 9 April 2014, 11.30 am. According to the coercive measures protocol, the fixation was assessed by an external physician on 8 January, 26 February and on 12 and 19 March 2014. After the first external medical assessment, 49 days passed before the next external medical assessment. The third external medical assessment took place 2 weeks later, whereupon 7 days passed before the fourth external medical assessment. Hereafter, no further external medical assessment took place according to the coercive measures protocol until the forced immobilisation ended 21 days later.

The management of the ward informed us during the monitoring visit that there was no doubt that external medical assessments had been undertaken. The physicians had informed the management that the 48-hour assessment had been entered in the coercive measures protocol, and that it was not customary practice to enter the subsequent external assessments in the coercive measures protocol – instead, these assessments would be entered elsewhere. The management informed the visiting team that the management would emphasise that the subsequent external assessments should be entered in the coercive measures protocol.

One visiting team recommended that the management in accordance with its statements initiated measures to ensure that applicable rules regarding completion of the coercive measures protocol were observed. During another monitoring visit, recommendation to follow up was given to the management as well as a recommendation to focus on discipline regarding completion of the coercive measures protocol.

When, for example, a forced immobilisation ends, the patient must be offered one or more follow-up sessions as soon as possible. The follow-up session is to clarify the

patient's and the staff's perception of the situation leading to the forced immobilisation. The intention of having such a session is to prevent the use of additional force and possibly to carry out force differently in the future. The report of the session must be registered.

The Ombudsman received reports of the subsequent sessions which had been carried out after the termination of the 54 forced immobilisations.

Subsequent follow-up sessions had not been held in a number of cases.

The examination of the reports regarding subsequent follow-up sessions indicated, among other things, that in a number of cases the reports did not clarify the staff's perception of the cause of the forced immobilisation.

During some of the monitoring visits, the management stated that it would discuss the issue of follow-up sessions and emphasising on the rules.

Feedback on reports of the use of force

During monitoring visits, the Ombudsman was also informed that psychiatric wards did not receive any feedback from the Danish Health and Medicines Authority on the reports sent to the Danish Health and Medicines Authority regarding the use of force. The Ombudsman took up the issue with the Ministry of Health. The Ministry stated that the Ministry would discuss the issue with the Danish Health and Medicines Authority.

Copenhagen, 1 June 2015

FOLKETINGETS
OMBUDSMAND

Themes for monitoring visits

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

The selection of a definite theme depends especially on where an additional monitoring effort is required. The Ombudsman often selects a narrow topic such as placement in solitary confinement cell under the Prison and Probation Service. At other times, the Ombudsman selects broad themes such as institutions for adults and treatment of alcohol and drug abuse.

The themes enable the Ombudsman to include current topics in the monitoring visits and to undertake an in-depth investigation of certain issues and to gain experience of practice, including best practice.

A principle aim of the carrying out of monitoring visits during that particular year is to clarify and investigate the themes of the year in question. In consequence of this, the main part of the annual monitoring visits are undertaken in institutions where the topics are relevant.

Thematic Reports

At the end of the year, the Ombudsman reports on the outcome of the monitoring visits during the year in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

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

General recommendations

The outcome of the themes may be general recommendations to the authorities such as, for example, a recommendation to draw up a policy for the prevention of inter-user violence and intimidation.

General recommendations are based on the Ombudsman's experience within the specific field. Such recommendations would normally be given to specific institutions during previous monitoring visits.

In general, the Ombudsman will discuss the follow-up on his general recommendations with key authorities. Furthermore, the Ombudsman will follow up on his recommendations during the monitoring visits.

The general recommendations are aimed at having a preventive effect. The reason for the preventive work within the monitoring area is based on the Ombudsman's task as National Preventive Mechanism pursuant to The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

The thematic reports are published on the Ombudsman's website www.ombudsmanden.dk. In addition to this, the Ombudsman also submits the reports to the relevant authorities so that the authorities can include the reports in their deliberations regarding the various sectors.

Coercive Measures Form

Case No**.:** _____

General information

Patient's age at commencement of fixation : _____

Patient gender: …….. ☐ Man ☐ Woman

Forensic psychiatric patient ☐ Yes ☐ No ☐ No information

Measure

Belt: …….. ☐ *– Duration: _____ days _____ hours*

Wrist straps: ……..... ☐ *– Duration: _____ days _____ hours*

Foot straps: ……. ☐ *– Duration: _____ days _____ hours*

Decision

<u>Who decided fixation with belt</u>**:**

The physician (section 15(1)) …… ☐ Nursing staff (section 15(3)) …… ☐

- Presented to the physician …….. ☐

- How long before the physician made a decision? _____ days _____ hrs

<u>Who took the decision to use hand straps and/or foot straps</u>:

The consultant psychiatrist (section 15(2)): ……. ☐

Another physician due to the consultant psychiatrist's absence (section 4a): ……. ☐

- Presented to the consultant psychiatrist …….. ☐

- How much time passed before the consultant psychiatrist made a decision? _____ days _____ hrs

Reasons for fixation:

"exposing oneself or others to likely risk of getting hurt …" (section 14(2)(i)) …….. ☐

"harassing or otherwise grossly abusing other patients" (section 14(2)(ii)) …….…….. ☐

"commits extensive acts of vandalism" (section 14(2)(iii)) …….... ☐

Consent (section 23 of the Consolidated Act on Coercive Measures) ……. ☐

Watch

Permanent watch (section 16) …….. ☐ Yes ☐ No ☐ No information

Regular medical assessments

Times of renewed medical assessment (section 21(4)) – *"at least 4 times a day, regularly undertaken during the day"*

- W*ere the times set with regular intervals during the day?* ☐ Yes ☐ No

Times of assessment undertaken by an external physician (section 21(5-6)) – *"after 48 hrs and repeated once a week")*

Information about possible disagreement between the external physician and the physician in charge:

Follow-up session

Has a follow-up session been carried out (section 4(5)): …… ☐ Yes ☐ No ☐ Offered

Does the follow-up session reflect **the patient's** perception as regards the reasons that led to fixation (section 1(2) of the Consolidated Act on follow-up sessions) …… ☐ Yes ☐ No

Does the follow-up session reflect **the staff's** perception as regards the reasons that led to fixation (section 1(2) of the Consolidated Act on follow-up sessions) …… ☐ Yes ☐ No

Remarks

For example, the use of gloves, (section 14(1)) and immobilisation of minors or immature 15-17-year-olds with the consent of the custodial parent, but against the will of the minor/the immature juvenile: