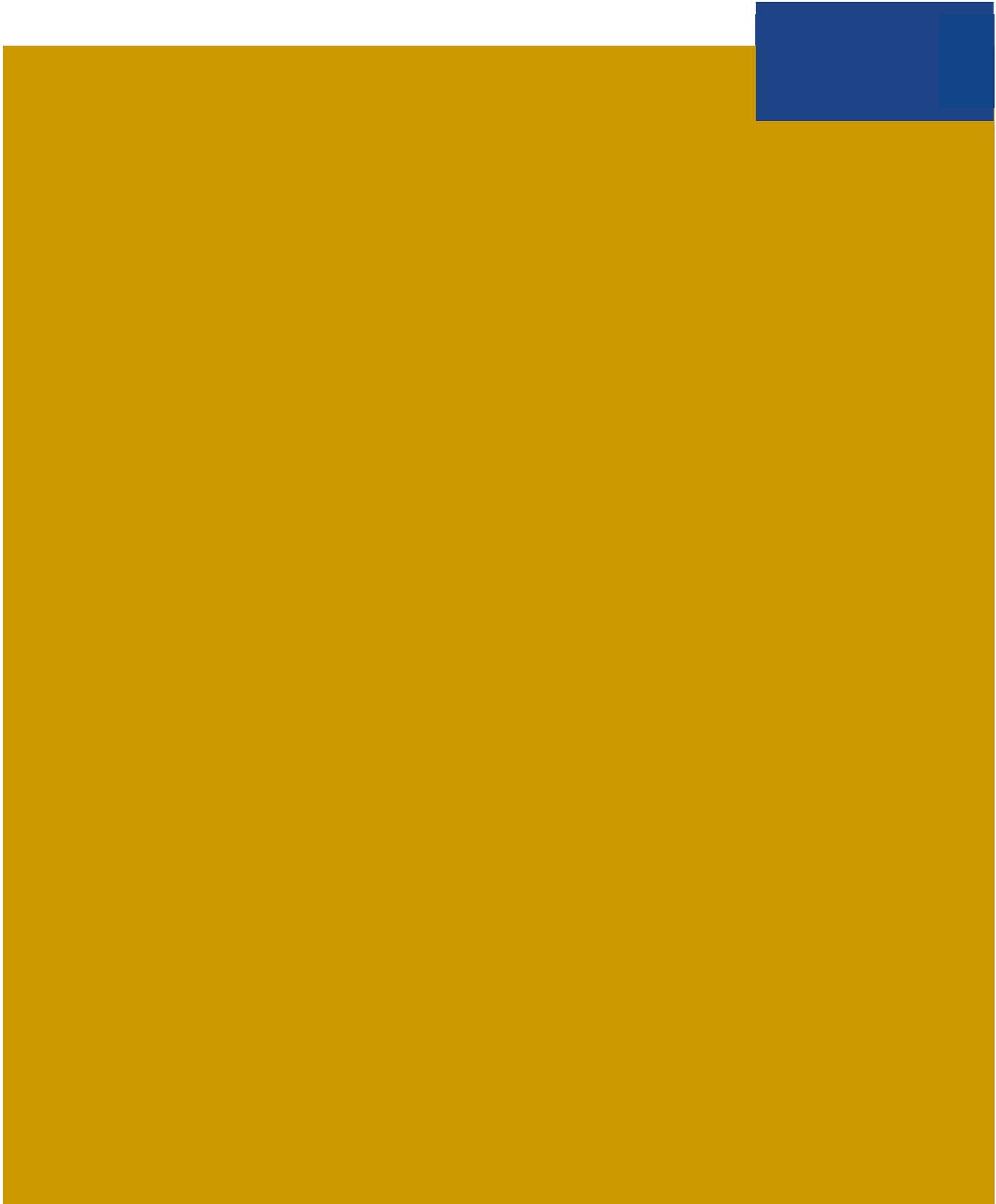




OPCAT Annual Report 2010



1. The Ombudsman as National Preventive Mechanism in 2010.....	3
2. Activities during the year	3
Visits	3
Investigations	7
International activities	8
3. Focus areas	8
Relationship between employees and persons deprived of their liberty	9
Medical conditions	9
Isolation	10
Use of force	10
Physical conditions	10
4. Working method	11
5. Inspections pursuant to Section 18 of the Ombudsman Act	15
6. Legal basis and organisation	16
7. Assessment basis	18
International legal basis	18
Citizens deprived of their liberty.....	19
The concept of torture.....	20
Cruel, inhuman and degrading treatment	21
The rights of those deprived of their liberty.....	22
Appendix 1	24

1. The Ombudsman as National Preventive Mechanism in 2010

The Parliamentary Ombudsman's work to, among other things, prevent degrading treatment of persons who are or may be deprived of their liberty started in 2009. The work is carried out in accordance to certain UN rules (Statutory Instrument No. 38 of 27 October 2009 concerning the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment). During 2009, the more detailed organisation of this work fell into place. As part of the work, we in 2009 carried out nine visits to institutions where there were or might be persons deprived of their liberty.

The work was intensified in 2010, when we carried out 20 visits. As part of the development of the work, a special theme for the visits was chosen in 2010, i.e. visits to institutions for mentally disabled people. Seven of the visits were to such institutions. The purpose of choosing a theme was to allow us to cross-reference and gather additional information about good practice, which could be disseminated for the benefit of the institutions. Having a theme made it possible to prepare a general report of all the experiences. This was sent to all the institutions for mentally disabled people which had been visited as well as the relevant local authorities and regions.

The work in 2010 also resulted in the development of the format of the visits. To a large extent, the visits take the form of a dialogue with the institutions and each visit ends with a talk with the management about the conditions at the institution. Thus, the final written report only contains information about matters of a more significant nature. In connection with the visits, greater attention was paid to the residents' access to psychiatric assistance.

In Chapter 2, activities during the year are outlined in greater detail. Chapters 3-4 cover focus areas and working methods. Chapters 5-7 contain an outline of the Ombudsman's ordinary inspection activities, the legal basis and organisation and the assessment basis.

2. Activities during the year

Visits

In 2010, the Parliamentary Ombudsman carried out 20 visits pursuant to the UN rules. The visits covered three remand centres, five county gaols, two psychiatric wards, one Prison Service pension, one closed state prison, the Prison Service prison for asylum

seekers (Ellebæk) and seven social residences (approved to receive sentenced mentally disabled persons). One visit was made without prior notice and 19 were announced visits.

With two exceptions (Næstved County Gaol and Næstved Remand Centre), all visits were carried out with medical assistance from the Rehabilitation and Research Centre for Torture Victims. The Institute for Human Rights took part in the visit to the Prison Service prison for asylum seekers, Ellebæk.

At all visits, the visiting teams spoke with one or more residents, prisoners or patients. However, the visiting teams did not speak with persons retained in the remand centres, as nobody was retained at the time of the Ombudsman's visits. A visiting team spoke with a person in isolation. The decision to isolate had been made by a court.

The visits covered the following institutions:

Ringsted County Gaol	23 June 2010
Næstved Remand Centre	1 July 2010
Næstved County Gaol	1 July 2010
The Institution for Asylum Seekers Deprived of their Liberty, Ellebæk	5 July 2010
Hobro Remand Centre	6 July 2010
Hobro County Gaol	6 July 2010
Randers Remand Centre	7 July 2010
Randers County Gaol	7 July 2010
Helsingør County Gaol	11 October 2010
Sjælør Residence, Copenhagen Municipality	19 October 2010
Ringe State Prison	25 October 2010
The Funen Contract Boarding House	26 October 2010
Ringbo, Copenhagen Municipality	28 October 2010
Havdrupvej, Copenhagen Municipality	3 November 2010
Bøge Allé 16, Region Southern Denmark	22 November 2010
Fuglekær Development Centre, Vejle Municipality	23 November 2010
Teglgårdshuset, Region Southern Denmark	7 December 2010
Østruplund, Region Southern Denmark	8 December 2010
Psychiatric ward P4 in Middelfart	13 December 2010
Psychiatric ward P2 in Middelfart	13 December 2010

The conditions at the institutions investigated were generally good and the overall impression was that a good effort was being made to ensure that the residents had the

best possible daily lives. The general impression was that the residents were treated well and with extensive account being taken of their individual needs. All visits were concluded with the Ombudsman finding no grounds for submitting written comments to the responsible authorities.

One case was not concluded until after the Ombudsman had questioned the relevant authority about a specific situation and reviewed the authority's reply. The case related to a visit at Helsingør County Gaol. The visit was a follow-up of a visit at the same county gaol in 2009. The 2009 visit, which was announced, gave the visiting team the impression that the relationship between certain employees and inmates could be improved. The Ombudsman therefore chose to make an unannounced follow-up visit to the county gaol on 11 October 2010. At the initial discussion, the management stated that there were no spokesperson arrangements at the county gaol. The interviews with the inmates revealed that one of the inmates – according to several of those interviewed – had been chosen as spokesperson for one of the sections of the county gaol. In May 2011, the Ombudsman was informed by telephone that there were currently no spokespersons for the sections of the county gaol. On this basis, the Ombudsman asked the Prison and Probation Service to assess whether the county gaol should give a higher priority to establishing a spokesperson arrangement at the institution in order to improve communication between inmates and employees. The Arrest Inspector for Zealand, Lolland, Falster and Bornholm informed the Prison and Probation Service that three of five sections currently had a spokesperson. The Prison and Probation Service then informed the Arrest Inspector that it presumed that the county gaol complied with the rules of the Spokesperson Order, i.e. the county gaol took the initiative for organising discussions with all inmates or groups of inmates during periods when the inmates had not chosen a spokesperson and that the inmates through notices or similar were informed about the possibility of choosing a spokesperson. The Ombudsman took note of the information provided and took no further action in the matter.

In some cases, the Ombudsman in the concluding letter to the institution mentioned specific matters which he had considered and why he found no grounds for making comments on them.

One of these cases related to Fuglekær Development Centre. During the visit to the centre, the Ombudsman became aware of a resident whose main door was locked at night. The resident did not have a key to the door and was therefore unable to get out. The centre was aware that this was not warranted by the Social Services Act. After the visit, the centre informed the Ombudsman by telephone that the resident had been

moved to another building where he was not locked in. On this basis, the Ombudsman took no further action and therefore concluded the visit by informing the centre that he found no grounds for submitting comments to the authorities responsible.

The visit to Teglgårdshuset was also concluded with the information that the Ombudsman found no grounds for submitting comments. In his assessment, the Ombudsman among other things attached importance to his appreciation that the employees were continuously aware of and after an actual assessment acted in relation to any problems that might arise in a house with active drug abuse. This, among other things, referred to cases of trade in drugs and medicine, 'fines for stupid behaviour' and debt between the residents.

In his concluding letter in the case concerning the visit to Ellebæk, the Ombudsman noted that a development plan had been prepared for the institution. In his opinion, the plan would result in improvement of the conditions at Ellebæk when implemented. The plan contained a description of a number of areas for improvement with associated result targets. The areas for improvement among other things related to matters that had been mentioned in a report by the European Committee for the Prevention of Torture etc. on its visit to Denmark in February 2008. Consequently, the Ombudsman concluded the case without comments.

At all visits, the Ombudsman received information which he noted for use in his subsequent work both on visits and in relation to other initiatives to prevent torture and other cruel, inhuman or degrading treatment or punishment. Most of the information related to the focus areas which are routinely investigated on visits, i.e. medical conditions, the relationship between employees and residents, use of force and isolation.

At two visits, Prison Service institutions stated that before the visits inmates had respectively attacked and raped other inmates. The Prison Service had reported this to the police. The persons reported to the police had been removed from the relevant institutions and the victims had received medical and psychological assistance. In addition, the Prison Service had taken the necessary steps to reduce the risk of future recurrences of similar actions. The situations therefore did not give the Ombudsman grounds for reacting in relation to the Prison and Probation Service, but at a meeting with the Prison and Probation Service, he has asked generally about the Prison Service's follow-up in cases where inmates are assumed to have been attacked or raped by fellow inmates.

In the general report, the Ombudsman described the visits to seven social residences and the results hereof. The report was sent to all the residences and their monitoring authorities with the concluding letters. The purpose of the report was to compile the Ombudsman's knowledge, experiences and observations and inform the relevant authorities. Generally, the Ombudsman, on the basis of the visits, concluded that management and employees showed great interest in and commitment and will to solve the challenges at the residences in the best possible way for the residents within the framework provided by the legislation. It is the Ombudsman's overall impression that the residents generally enjoyed living at the residences. Their relatives also expressed general satisfaction with the residences. The residences' collaboration with police, public prosecutor and psychiatric services was generally good. However, some residences were experiencing problems in getting the psychiatric service to assume responsibility for residents for whom the institutions in specific cases felt unable to take responsibility. One residence experienced similar problems in relation to the police. The Ombudsman will continue to pay attention to these problems. In the report, the Ombudsman also described three different initiatives which had attracted the visiting teams' particular attention. One initiative was a form which a residence used to get an overview of the effect of a resident's sentence and which contact persons were available. The second was a form for registering violence and threats of violence towards the employees. The last was performance appraisals with the residents. All visits concluded with information that the Ombudsman found no grounds for making comments. The report is included as Appendix 1.

Investigations

On 28 September 2010, I asked the Prison and Probation Service, the Data Protection Board and the Ministry of the Interior and Health for statements on a case concerning the passing on of information in county gaols. I submitted the matter to the authorities because I was considering whether there was a basis for initiating an own-initiative investigation of the passing on of information in the patient files established about inmates in county gaols and used by the county gaol doctor as part of the treatment of the inmates. I was referring to the passing on of information involved when people other than the gaol doctor have access to the files and are able to use the information. The background for my considerations included the statements about passing on of information which I had received during some visits which I had made to county gaols pursuant to the UN regulations. The authorities have made statements. The case is pending.

As an offshoot of the case concerning the police handling of detainees during the Climate Summit in Copenhagen in 2009, the media in late 2010 carried stories about

some of the police team leaders allegedly using language of a rather unusual nature during actions in connection with the demonstrations. A team leader was thus quoted as among other things for ordering the policemen: "Now I bloody well want to see that truncheon red-hot when we go for that car. Full speed ahead through that shit. Over and out." The Ombudsman asked the Ministry of Justice to state, among other things, at which time and in which circumstances these commands had been given and where the team leader was located at the relevant time. In addition, the Ministry was asked for a statement on the actual content of the commands ordering extensive use of the truncheon and the explicit encouragement by the team leader to include media representatives in the use of force as well as on the reactions by the police management that might be occasioned by the case. The Ministry has responded. The case is pending.

International activities

The Ombudsman has participated in a number of seminars under Council of Europe auspices with a view to strengthening the member states' efforts to prevent torture and cruel, inhuman and degrading treatment. The Ombudsman participated in seminars in Padua, Italy on 27-28 January 2010, in Tirana, Albania on 9-10 June 2010, in Jerevan, Armenia on 13-14 October 2010 and in Strasbourg, France on 1-2 December 2010. The seminars have among other things dealt with the countries' role in protecting the individual's core rights in case of police detention, preparation and planning of visits, medical conditions during detention and the use of experts. In addition to the member states, members of the UN Sub-Committee on the Prevention of Torture and the European Committee for the Prevention of Torture etc. have taken part.

On 3-5 October 2010, Ombudsman Hans Gammeltoft-Hansen and commissioner Jon Andersen took part in the International Ombudsman's Institute conference in Barcelona, Spain where the organisation of the world's Ombudsmen's work with visits pursuant to the UN rules, etc. was discussed. Also, the Armenian Ombudsman was our guest at our visit to Slagelse County Gaol, and we have given talks about our activities to Jordanian high court judges and chief prosecutors as well as to the Estonian Ombudsman. Furthermore, we have corresponded about our experiences from visits pursuant to the UN rules in Denmark with a number of newly established national preventive mechanisms in various Eastern European countries.

3. Focus areas

The purpose of the Ombudsman's visit pursuant to the UN rules is primarily to prevent torture or other degrading behaviour or punishment in places where persons either are or may be deprived of their liberty. This purpose implies that the Ombudsman at the visits must pay particular attention to for instance general conditions which may develop in such a way that the residents in an institution are treated in a degrading way. This may include waiting time for toilet visits, failure to investigate damage at the residents or long-term immobilisation. At the same time, it clearly is not the Ombudsman's task to look at every condition in the institutions which he visits pursuant to the UN rules.

In his work as national preventive mechanism, the Ombudsman has chosen to focus on a number of areas which are regarded as particularly relevant to fulfilling the special monitoring task. The choice of focus areas for the visits is among other things based on the experiences highlighted in reports about Denmark by the European Committee for the Prevention of Torture etc. and the UN Committee against Torture as well as the knowledge already acquired by the Parliamentary Ombudsman, the Rehabilitation and Research Centre for Torture Victims and the Institute for Human Rights about the conditions of persons deprived of their liberty in Denmark.

The UN Sub-Committee on the Prevention of Torture has carried out inspections since 2009. The relevant results of these inspections are included as a basis for selecting the areas which the Ombudsman will handle in his function as national preventive mechanism.

Relationship between employees and persons deprived of their liberty

These experiences show that the relationship between citizens deprived of their liberty and the employees who treat and guard them is of crucial importance. This applies equally to prisoners, patients at psychiatric centres, children and young people in secure institutions, dementia-sufferers in nursing homes and aliens in asylum centres. This particular relationship is therefore an important focus area during the visits. In this connection, attention is paid to information about the way in which communication between employees and those deprived of their liberty is handled, employee allocations, employee education and training, the management's guidance and monitoring of the appropriate approach by the employees, the employees' way of carrying out care tasks, etc.

Medical conditions

A special aspect of ensuring that those deprived of their liberty are treated in a dignified, humane and torture-free way is ensuring that they receive sound and effective

medical services. As a starting point, those deprived of their liberty should have at least the same access to medical treatment as those who have their liberty. In addition, the deprivation of liberty may, depending on the circumstances, in itself cause particular health problems which can only be resolved by special medical expertise. Another recurrent problem is that deprivation of liberty is often used against persons who are already ill, for whom (continued) treatment is crucial.

The specific circumstances relevant in this context depend on the types of institution and residential offer visited. Clearly, the medical conditions considered during the visits will not be the same in a prison and a psychiatric centre.

Isolation

Many investigations show that people who are not only subject to limited mobility but also isolated from contact with other people are particularly exposed. Experiences also show that the sensitivity of a person to the effects of isolation varies greatly. However, the general picture is that most people are seriously mentally affected by exposure to isolation, even for short periods of time. This circumstance, together with the fact that the international bodies have repeatedly pointed out that especially Danish prisons use isolation more than those in other countries, has resulted in isolation also being chosen as a particular focus area. During the visits, attention will be directed at the number of persons who are isolated, the extent and conditions of the separation of the individual from others and any harmful effects of too lengthy or restrictively imposed isolation.

Use of force

Use of force may be necessary to carry out the deprivation of liberty itself, but can also be difficult to avoid entirely in maintaining the deprivation or in connection with the treatment of the person deprived of liberty. Here, too, it varies greatly when and how use of force is applied in the different types of institution. In simple terms, force is used in prisons, etc. to implement and maintain the deprivation of liberty, while force in hospitals and treatment offers is used to protect the persons against themselves or others. Irrespective of the reason, there is always a risk that the use of force will develop into an infringement of the prohibition against torture, etc. The use of force has therefore been chosen as a special area of attention during the visits.

Physical conditions

The physical conditions (size of cell/room, furnishing of room, building conditions, maintenance, diet, outdoor areas, activity offers, etc.) offered to inmates/residents have rarely provided grounds for comment in Denmark. Such conditions are monitored

at the Ombudsman's ordinary inspections pursuant to Section 18 of the Ombudsman Act rather than separately in connection with the visits pursuant to the UN rules. Such matters are only investigated by the Ombudsman as national preventive mechanism in case of specific indications of shortcomings (such as complaints by inmates/residents) and on a random check basis. This prioritisation is not due to such matters being considered irrelevant to the work, but rather because the area is already to some extent monitored and experience has shown that, in this respect, the conditions of those deprived of their liberty are generally of a good standard.

4. Working method

Visits are the core measure in the work pursuant to the UN rules. Correspondingly, our work is structured around visits to the locations where persons are or may be deprived of their liberty.

According to the UN rules, prevention of torture, etc. requires 'education and a combination of various legal, administrative, judicial and other measures'. It is emphasised that the prevention of torture 'may be strengthened by non-judicial means of a preventive nature on the basis of regular visits to locations where persons are detained'. According to the UN's special reporter on torture, the rules must be understood to mean that the preventive visits require a multi-disciplinary approach. This implies that each visiting team must include both legally and medically trained personnel.

In Denmark, the visiting team normally comprises two lawyers from the Ombudsman office and a doctor from the Rehabilitation and Research Centre for Torture Victims. In rare cases, the Institute for Human Rights also participates in the visits.

The Ombudsman chooses the institutions to be visited in collaboration with the Rehabilitation and Research Centre for Torture Victims and the Institute for Human Rights. In 2010, the Ombudsman decided that most of the visits should be to particular types of institution. Thus 15 of the 20 visits in 2010 were at three types of institution (five county gaols, three detentions and seven social residences).

Visiting several institutions of the same type gives the visiting teams a good insight into the individual institution types. The visiting teams are also immediately able to combine knowledge, experiences and observations about the same type of institution. The visiting teams can for instance share this information with the institutions and include it in the discussions with the institutions. In this way, the visiting teams can also

get an impression of whether a practice is common within the area or specific to a particular institution. At the same time, it is important to remember that it is also valuable for the visiting teams to see different types of institution because information in this way can be combined across institution types, for instance the visiting team can combine information about the employees' approach to the use of force at social institutions with information about the employees' approach to the use of force at psychiatric wards.

Normally, the Ombudsman announces his visits to the institution and the supervisory authority. Advantages of announced visits include that the visiting team can obtain information from the institution before the visit and that the relevant people are present at the institution at the day of the visit. In 2010, all visits but one were announced.

Prior to the visits, the Ombudsman asks the institution to be visited for various information. The purpose is to provide the visiting team with information about the conditions at the institution before the visit, including for instance the institution's use of force. This ensures that the visiting team is better equipped to focus on the issues which are particularly relevant to the individual institution.

As a starting point, the Ombudsman asks for the same information from all institutions during a visiting year. At the same time, changes may of course be made, just as special conditions may need to be investigated at particular institutions or types of institution.

Information collected in connection with the visit includes statistical data. The visiting teams may also review files and ask for copies of particular case documents. Various reports and information on the institutions' websites are also considered. In addition, the work takes in the legal framework of the treatment of those deprived of their liberty.

Dialogue plays a major part in the visits.

A visit thus normally starts with a meeting with the management and others. The discussion at the meeting normally takes the focus areas and the material provided to the visiting team in advance as its starting point, for instance the tone at the institution is usually discussed. Specific incidents at the institution may also be discussed.

During the visit, the visiting team usually speak with employees and residents as well as the management. Often, they also speak with medical personnel, resident representatives and relatives. The visiting team ensure that consent is obtained from, for

instance, the residents if information from the interviews is passed on to the management.

The visiting team also tour parts of the institution. The tour gives the visiting team an impression of the atmosphere and daily life at the institution. During the tour, the visiting team often ask further questions and also frequently speak with for instance employees and residents whom they meet.

The information and experiences which the visiting team obtain in this way, together with their observations, are used in various ways.

Most importantly, the visiting team pass on relevant information to the management at the concluding meeting. This may include actual complaints or wishes from the residents. The visiting team also give the management verbal and immediate feedback on their visit and the thoughts which the team have had during the visit. The meeting may also include discussions of problems of a general nature, for instance the relationship between the institution and other sectors such as the local authority, police and psychiatric service.

In addition, the information may be used as a basis for making recommendations or other comments to the institution and the responsible authorities.

Most recommendations and comments are made verbally at the concluding meeting. If the responsible authorities agree with the comments and state that they will be implemented, they are usually not repeated in the concluding letter about the visit. At the concluding meeting, the visiting team may also merely mention circumstances or ideas for the authorities to consider in their further work.

In some cases, the Ombudsman will submit recommendations or other comments to the authorities in writing. In such cases, the Ombudsman will ask the authorities for a written statement before deciding whether he has grounds for submitting recommendations or other comments.

The visit may also alert the visiting team to problems which will subsequently be further explored through new visits, either new visits to other institutions/types of institution or follow-up visits to the same institution.

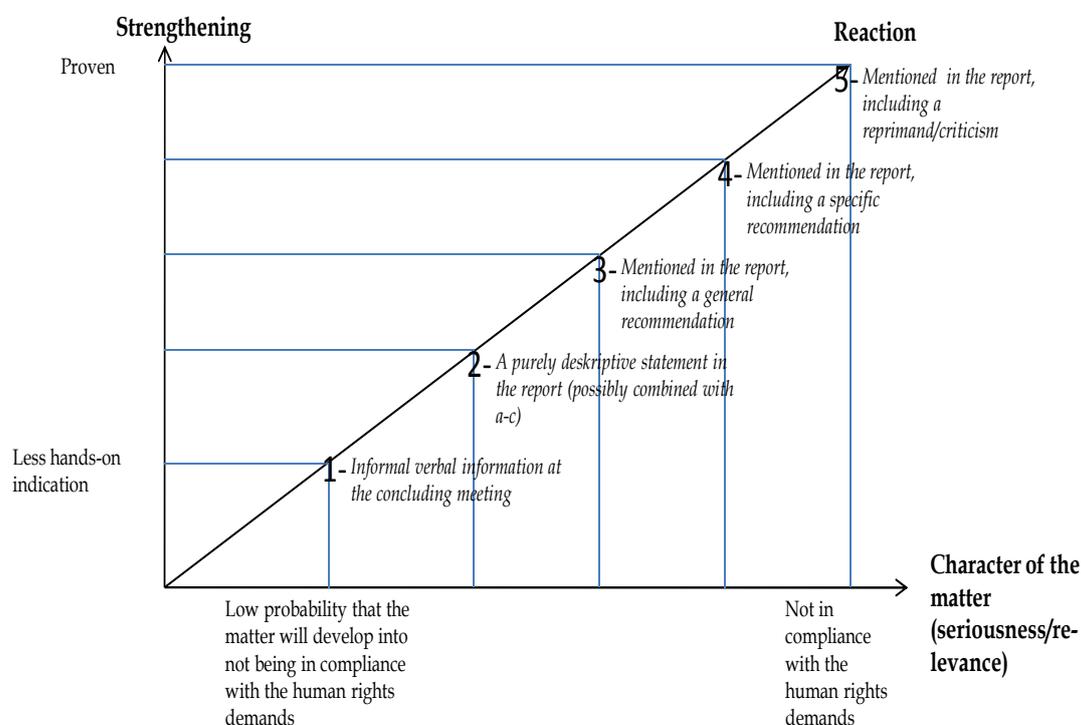
In cases where the Ombudsman finds no grounds for submitting written comments to the responsible authorities, the visit is concluded with a brief letter to the institution.

The letter comprises a description of the visit and the Ombudsman's assessment of the conditions. The Ombudsman has chosen to prepare short letters in these cases because he wishes to use his resources in the best possible way.

When the Ombudsman concluded the seven cases involving visits to social residences in 2010, he also chose to send a general report about all seven visits to the residences and the supervisory authorities along with the concluding letter. The purpose was to gather the Ombudsman's knowledge, experiences and observations from the visits and inform the relevant authorities of these.

Other methods apart from visits are also used to investigate and prevent torture, etc. For instance, the Ombudsman may on his own initiative take up cases for investigation and request information, statements and documents in the cases. This power may be combined with visits, for instance information received in connection with a visit may form the basis of the Ombudsman taking up a case on his own initiative. Media coverage may also form the basis of the Ombudsman deciding to take up a case on his own initiative.

In spring 2010, the Rehabilitation and Research Centre for Torture Victims, the Institute for Human Rights and the Parliamentary Ombudsman held a full-day conference with a view to, among other things, discussing and deciding on the reaction level in relation to the authorities. At the conference, there was agreement that the reaction level should be determined on the basis of an actual assessment of how strengthened each matter could be regarded as being as well as the seriousness of the relevant matter. As a starting point, the reaction should follow the steps in the graph below:



The Ombudsman bears these considerations in mind when he decides whether there are grounds for making recommendations or other comments to the responsible authorities and, if so, what content for instance a recommendation should have.

5. Inspections pursuant to Section 18 of the Ombudsman Act

In 2010, the Parliamentary Ombudsman carried out 22 inspections pursuant to Section 18 of the Ombudsman Act. Of these, 15 were at places where persons are deprived of their liberty. More information about the inspections can be found on the Ombudsman's website, www.ombudsmanden.dk under The Ombudsman and Inspections. The inspections have provided grounds for numerous critical comments and recommendations. During the inspections, no situations covered by the concept "torture and other cruel, inhuman or degrading treatment or punishment" were observed.

6. Legal basis and organisation

On 19 May 2004, the Danish Parliament (Folketinget) agreed to ratify the Optional Protocol of the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. These UN rules require the participating states to establish a system of regular visits by independent bodies to places where persons are deprived of their liberty in order to prevent torture, etc. Each participating state is obliged to establish one or more national authorities to prevent torture, etc. – the national preventive mechanism.

In spring 2007, the Danish government chose the Parliamentary Ombudsman as the Danish national preventive mechanism.

The tasks of the national preventive mechanism are described in detail in Article 19 of the Protocol. The main task is to carry out visits to places where persons are deprived of their liberty on a regular basis in order to strengthen the protection against and prevention of torture and other degrading and inhuman treatment. In addition, the national preventive mechanism shall make recommendations to the relevant authorities with a view to improving the treatment and conditions of persons deprived of their liberty. Finally, the national preventive mechanism shall make suggestions and comments in relation to existing or proposed legislation.

Both the visiting activities and the rest of the work are assumed to have a special preventive purpose. This implies a particular obligation to pay attention to general conditions relevant to any potential risk in the long term of torture or other degrading or inhuman treatment.

Article 4.1 of the UN Protocol states that the inspections shall be targeted at the treatment of persons found in places where they are or may be deprived of their liberty. Article 4.2 of the Protocol defines deprivation of liberty as “any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority”.

Among other things to ensure that the Parliamentary Ombudsman has the necessary authority to carry out visits to private institutions pursuant to the UN Protocol mandate, the Ombudsman Act was amended in June 2009 (Act no. 502 of 12 June 2009). The legal change in this respect involved a change of Section 7, sub-section (1) of the Ombudsman Act, which now states: “The Ombudsman’s activities shall extend to all parts of

the public administration. The Ombudsman's activities shall also cover the conditions of persons deprived of their liberty at private institutions, etc. where the deprivation of liberty is pursuant either to a decision by a public authority or with the consent or agreement of a public authority."

These institutions shall provide information, submit documents and prepare written statements to the Ombudsman, cf. Section 19, sub-sections (1) and (2). In addition, Section 19, sub-section (5) of the Act states: "The Parliamentary Ombudsman shall, if it is deemed necessary, at any time against suitable identification without a court order have access to inspect private institutions, etc. where persons are or may be deprived of their liberty, cf. Section 7, sub-section (1.2). If necessary, the police shall assist in the implementation of this."

When Folketinget authorised the Ombudsman to handle the task of national preventive mechanism, it at the same time presumed that the Rehabilitation and Research Centre for Torture Victims and the Institute for Human Rights were able to make persons with special medical and human rights expertise available for the Ombudsman's work as national preventive mechanism. Folketinget increased the Ombudsman's budget for 2009 and beyond by approx. DKK 2 million, corresponding to 2.5 persons' work per year, in order to enable the Ombudsman to undertake the new task. In 2010, the Institute for Human Rights did not receive public funding, while the Rehabilitation and Research Centre for Torture Victims received DKK 200,000 to make specialist medical expertise available for the work. In future years, the Rehabilitation and Research Centre for Torture Victims may receive up to DKK 400,000 for its assistance. The funding of the Centre is part of the Budget allocation to the Ministry of Foreign Affairs. In 2010, the Institute prioritised its work on the council and spent less time on participation in working group meetings (see below), visits and other activities.

As already mentioned, the authority to handle the task of national preventive mechanism rests with the Parliamentary Ombudsman. The Rehabilitation and Research Centre for Torture Victims and the Institute for Human Rights have an advisory function in the collaboration. However, the Ombudsman has indicated that he will attach decisive weight to the expert contributions he receives from the two organisations and that he will reflect any divergent opinions in his reports if the organisations so wish.

The management of the three organisations meet a few times a year to discuss and plan the overall guidelines for the work. This collaboration is called *the council*. Each organisation has appointed specific employees to participate in the ongoing work with the actual visiting activities, preparation of reports and statements in relation to

new legislation. The Parliamentary Ombudsman employees act as secretariat to the working group and have overall responsibility for planning the work. This part of the collaboration is called *the working group*.

The Ombudsman already carries out inspections pursuant to Section 18 of the Ombudsman Act. These inspections – ordinary inspections – are not only carried out at places where persons are deprived of their liberty and they cover a wide range of matters, some of which fall within, but many of which fall outside the special focus areas which the national preventive mechanism has to monitor pursuant to the UN rules. These inspections are administered by a different department at the Parliamentary Ombudsman and are not a direct part of the monitoring work carried out pursuant to the UN rules. In connection with the ordinary inspections, attention is directed at the special issues in relation to the treatment of persons deprived of their liberty which are covered by the Ombudsman's work as national preventive mechanism. The two departments inform each other about their work and results on a regular basis.

7. Assessment basis

International legal basis

Pursuant to Article 19 of the Protocol, the national preventive mechanism may make re-recommendations to the relevant authorities with a view to improving the treatment and conditions of persons deprived of their liberty and to prevent torture and cruel, inhuman or degrading treatment or punishment in accordance with the relevant UN standards. These may for instance include:

- Relevant UN conventions ("hard law") concerning torture and inhuman treatment, including especially the UN Convention against Torture, the UN Convention on Civil and Political Rights and the UN Convention on the Rights of the Child as well as the European Human Rights Convention and practice by the European Court of Human Rights
- Relevant UN declarations, resolutions and principles ("soft law"), including especially the Standard Minimum Rules for the Treatment of Prisoners (1997), the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988), the United Nations Rules for the Protection of Juveniles deprived of their Liberty (1990), the Code of Conduct for Law Enforcement Officials (1979) and the Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Inhuman and Degrading Treatment or Punishment

- Relevant practice from the human rights monitoring bodies, including especially the UN Human Rights Council, the UN Committee against Torture and the UN Sub-Committee on the Prevention of Torture, etc.

In addition, relevant Danish rules and Danish legal usage are taken into account, along with the Council of Europe prison rules of 2006 and practice by the European Committee for the Prevention of Torture, etc.

Furthermore, various international human rights organisations have prepared guidelines and manuals for prison visits. The Association for the Prevention of Torture has thus prepared a detailed manual for the inspection work, "Monitoring Places of Detention" and "Implementation Manual", on the basis of the UN Protocol.

In the nature of things, the conventions and the practice of the international courts, especially the European Court of Human Rights, in relation to the interpretation of and in compliance with the conventions play a particular part in the assessment of the matters investigated by the Ombudsman as national preventive mechanism.

Citizens deprived of their liberty

The monitoring work is directed at the treatment of persons deprived of their liberty at the instigation of a public authority. As mentioned above, Article 4.2 of the UN Protocol defines the concept "deprivation of liberty" as "any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority". In connection with the planning of the work, it has been taken into account that this not only refers to persons deprived of their liberty as the term is defined in Article 5 of the European Human Rights Convention, but also to persons whose mobility is in practice restricted.

The Ombudsman is thus competent in relation to institutions where persons are placed directly as a result of a decision made by a public authority or where such placement happens with the consent or acceptance of a public authority. Such involvement or acceptance is certainly present when a public authority makes a direct decision to place a person in a private institution, in cases where public authorities pay for a placement which has been decided by private persons and in situations where private persons decide on placement in private institutions approved by public authorities for such a placement. The term deprivation of liberty must be understood broadly as both specific legal deprivation of liberty and actual restriction of the person's ability to choose where to be. The provision covers cases where children or young people are placed in private

institutions or boarding schools pursuant to the Social Services Act either compulsorily or with the consent of their parents. The placement of elderly people in nursing homes or mentally disabled persons in private residences may also be in the nature of deprivation of liberty, either because the placement itself is compulsory pursuant to Section 129 of the Social Services Act or because the persons placed in these institutions may be subjected to compulsory measures pursuant to Sections 124-128 of the Social Services Act. The preliminaries to the Protocol indicate that the placement of physically disabled persons may also be covered by the Protocol. The Ombudsman's visiting activities therefore cover private residences, institutions, schools, homes, hospitals, nursing homes, etc. looking after weak people who are not realistically able to live anywhere else. However, as mentioned above, it is a condition that a public authority has either made or contributed to the decision of the placement.

The concept of torture

Article 1 of the UN Convention against Torture defines torture as follows:

“For the purposes of this Convention, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

2. This article is without prejudice to any international instrument or national legislation which does or may contain provisions of wider application.”

Section 157 a, sub-section (2) of the Danish Penal Code contains the following definition of torture:

“By torture is understood infliction on another person of harm to body or health or severe physical or mental pain or suffering for the purpose of obtaining information or confessions from someone, to punish, frighten or force someone to do, tolerate or not do something or due to the person's political conviction, gender, race, skin colour, national or ethnic origin, faith or sexual orientation.”

This limitation implies that special attention must be paid to information about the health conditions of those deprived of their liberty, their medical treatment, the organisation of medical assistance, use of force and violence or other physical harm. As discrimination is part of the definition of torture, special attention must be paid to groups which are particularly vulnerable to discrimination, are or risk being treated contrary to the prohibition of torture, etc.

Cruel, inhuman and degrading treatment

The UN rules also cover prevention of cruel, inhuman and degrading treatment.

In the practice of the European Court of Human Rights in relation to the interpretation of the corresponding provision in Article 3 of the European Human Rights Convention, these terms cover a broad range of situations. The European Court of Human Rights has defined “inhuman” treatment as “severe physical or mental suffering”. The Court has in particular attempted to define and clarify the meaning of degrading behaviour. In assessing whether treatment is degrading, the Court has attached importance to whether the treatment resulted or might result in a feeling of fear, anxiety or inferiority calculated to humiliate or demoralise the victim.

The public nature of the treatment is relevant to the assessment of whether the treatment is degrading, but the treatment does not necessarily have to be public in order to be degrading. It may be enough that a person in his or her own opinion has felt humiliated.

The European Court of Human Rights has made quite a few judgements on the issue. The decisions are to a large extent influenced by the specific circumstances of the cases, but some general trends can be deduced from the practice.

The Court takes as its starting point that inappropriate treatment of the citizens must be reasonably serious to constitute an infringement of Article 3. It must go beyond the element of suffering and humiliation which is often an inevitable result of legal treatment, force and punishment.

In connection with the actual assessment of whether the strain is disproportionate, particular weight is attached to the intention behind the treatment and its physical and mental effect on the person. As a starting point, actions which according to conventional opinion can result in a feeling of fear, anxiety or inferiority in those deprived of their liberty are not permissible. Similarly, interventions for the sole purpose of inflicting pain, suffering or degradation are unacceptable.

Legal use of force is not contrary to Article 3, but force may only be used if it is unavoidable and the use of force may not be excessive.

Whether rough treatment is acceptable is closely connected with whether the citizens were deprived of their liberty as part of legal use of power. The mere fact that an actual assessment suggests that the deprivation of liberty was not legal is unlikely to affect the assessment of the nature of the treatment. By contrast, the assessment is likely to change its nature if the deprivation of liberty is clearly or seriously illegal, for instance if persons are deprived of their liberty at an institution where such deprivation is not allowed at all or if the deprivation of liberty has been implemented completely arbitrarily or as a private act of vengeance.

In addition, great importance is attached to the duration of the deprivation of liberty: the longer it lasts, the better the treatment has to be. Conversely, it is acceptable that those deprived of their liberty are subjected to even very unpleasant conditions if the deprivation of liberty lasts for a very short time. The number of cases where infringement is deemed to have taken place in connection with brief deprivation of liberty is very small. The amount of space offered to those deprived of their liberty may be extremely limited, even in cases where the deprivation of liberty is very extended. Irrespective of the duration of the deprivation of liberty, it must always be taken into account whether those deprived of their liberty are particularly vulnerable because they suffer from a serious somatic illness, are mentally ill, of poor health or very young or elderly. Some consideration of whether those deprived of their liberty are male or female also plays a part.

In practice, there is no hard and fast boundary between behaviour which contravenes Article 3 of the European Human Rights Convention and actions which by Danish standards are unacceptable because they demonstrate a lack of consideration or respect. In connection with the visits, no sharp distinction is made between these different categories, partly because the purpose of the control is both reactive and proactive.

The rights of those deprived of their liberty

As a starting point, persons deprived of their liberty have the same rights as other citizens in society, apart from the limitation of their personal liberty. Thus, they retain all rights which were not legally removed from them by the decision which deprived them of their liberty.

The fundamental human rights principle that all persons must be treated with respect for their integrity and dignity thus also applies to those deprived of their liberty. Trans-

lated into practice, it implies that those deprived of their liberty must have access to reasonable accommodation, sleep, food and drink, personal hygiene and toilet visits. As far as possible, those deprived of their liberty also have the right to maintain contact with the outside world, including regular contact with family and other persons by letter, telephone and visits. In addition, those deprived of their liberty have the right to external legal assistance and medical and other health-related assistance to treat diseases and injuries.

In connection with the use of force, a medical examination must be carried out if disease or injury is suspected or if the persons deprived of their liberty themselves request medical assistance. If marks and wounds appear after the deprivation of liberty, the burden of proof that there has been no mistreatment rests with the authorities. The employees responsible for the arrest and surveillance are obliged to show respect towards the inmates in both language and actions. Those deprived of their liberty must be addressed and spoken about without abuse, but must also accept that the tone, depending on the situation, may be direct, commanding and rougher than demanded by ordinary politeness.

When particularly vulnerable groups, such as women, children and foreigners, are deprived of their liberty, the authorities must take account of any special physical, mental, social and other needs of these groups.

Appendix 1

CONCERNING VISITS TO SEVEN DOMICILES PURSUANT TO SECTION 108 OF THE SOCIAL SERVICES ACT

Purpose

In 2010, the Ombudsman visited seven residences which were domiciles pursuant to Section 108, sub-section (1) in the Social Services Act (now Consolidated Act No. 81 of 4 February 2011). The residences were for adults.

Apart from my employees, all visits included a doctor from or associated with the Rehabilitation and Research Centre for Torture Victims. One visit included two doctors from the Rehabilitation and Research Centre for Torture Victims. The doctors took part in all aspects of the visits and, in the nature of things, paid particular attention to the medical conditions at the institutions.

I chose to visit domiciles pursuant to Section 108, sub-section (1) of the Social Services Act, because these domiciles might include residents who either were or might become deprived of their liberty. In addition, I wished to obtain more information about and experiences of the treatment and conditions of those living at such residences.

The overall purpose of the visits was to prevent that persons who were or might become deprived of their liberty were subjected to torture and other cruel, inhuman or degrading treatment or punishment. I thus did not inspect all conditions at the residences.

The visits took place pursuant to the rules in the executive order concerning the Optional Protocol of 18 December 2002 to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Executive Order No. 38 of 27 October 2009). The Ombudsman's work pursuant to these rules is carried out in collaboration with the Rehabilitation and Research Centre for Torture Victims and the Institute for Human Rights.

Domiciles pursuant to Section 108 of the Social Services Act

The local authorities shall offer accommodation in domiciles suitable for long stays. The offer must be given to persons who need extensive help towards ordinary, daily functions or nursing, care or treatment due to significant and lasting physical or mental disability and who cannot have these needs met in other ways. This is laid down in Section 108, sub-section (1) of the Social Services Act.

The local authorities shall make decisions on placement in domiciles pursuant to Section 108, sub-section (1) for persons who by order of the court must undergo a mental examination or who pursuant to a sentence or order or as a condition of withdrawal of a charge or conditional release must be placed in a domicile for persons with considerable mental disability or subjected to supervision, including the possibility of administrative placement. See Section 17, sub-section (1) in the Executive Order concerning the Use of Force and other Interventions in the Right of Self-Determination in relation to Adults and concerning Special Security Measures in relation to Adults and Acceptance Obligation in Domiciles pursuant to the Social Services Act (Executive Order No. 688 of 21 June 2010).

The employees may use physical force to restrain persons or lead persons to another room if there is an immediate risk that the persons will expose themselves or others to significant personal injury and the circumstances in the individual case make it absolutely essential. The employees may use such force towards persons with significant and lasting mental disability who receive personal and practical assistance and social worker assistance, treatment or activating offers and do not consent to the use of force. See Section 124, sub-section 5, Section 124 a and Section 126 of the Social Services Act. The employees may also act in self-defence or *jus necessitatis* pursuant to the rules in Sections 13-14 of the Penal Code (now Consolidated Act No. 1235 of 26 October 2010).

The individual residences and their residents

The Ombudsman visited the following residences:

- Sjælør Residence, which had 19 disabled residents. The residents lived in several houses in Valby.

- Ringbo Residence Centre, which is a social-psychiatric centre. Most of the 155 residents lived in the domicile pursuant to Section 108, sub-section (1) of the Social Services Act. The centre consists of a number of houses in a park in Bagsværd.
- Havdrupvej Residence, which had four disabled residents. The residents lived in an old villa in Brønshøj.
- Bøge Allé 16, which had 12 disabled residents. The residents lived in several buildings on an old institution site in Ribe.
- Fuglekær Development Centre, which had 38 residents with mental disabilities. Most residents lived in the domicile pursuant to Section 108, sub-section (1). The visit was made to Fuglekærgård, which is located in rural surroundings outside Børkop.
- Teglgårdshuset, which among other things consists of a social-psychiatric accommodation offer for 17 persons with mental illnesses and active drug abuse. The residents lived in an old building in Middelfart.
- Østruplund, which had 34 mentally and physically disabled residents. Most residents lived in a castle in rural surroundings outside Otterup. The visit was made to the castle.

As seen above, the residences were housed in very different buildings. Several residences had specific plans to move to other buildings, build new houses or rebuild.

As far as possible, the visits were carried out by interviews with the management, the employees, the residents and their relatives. Thus, the visiting teams spoke with management and employees during all visits. However, at one residence, the visiting team did not speak with any employees. The visiting teams also spoke with residents and relatives in all residences, apart from a residence where the visiting team did not speak with any relatives. In total, the visiting teams spoke with 22 residents, one external user and 11 relatives. The visiting teams also toured sections of the residences.

Sjælør Residence, Ringbo Residence Centre and Havdrupvej Residence come under Copenhagen Municipality. Bøge Allé 16, Teglgårdshuset and Østruplund come under Region Southern Denmark and Fuglekær Development Centre comes under Vejle Municipality.

Focus areas

At the visits, the relationship between employees and residents, medical conditions and the use of force were chosen as focus areas.

Before the visits, I among other things – in so far as the material was available – received:

- Information about the current resident composition (such as age, gender and foreign origin) with information about the number of residents with a court order and what the court had ordered
- Supervision reports
- Information about organisation, staffing and finances
- Information about the number of cases involving the use of force and reporting of violence to the police in 2010
- Examples of an action plan and administration agreement with individual residents
- Guidelines for the use of force and reporting of violence to the police
- Minutes of resident and relative committee meetings
- House rules

Result of the visits

On the basis of the visits, I was generally impressed with the management's and employees' interest in, commitment and will to solving the challenges at the residences in the best possible way for the residents within the framework established by the legislation. It was my overall impression that the residents were generally happy to stay at the residences. The relatives also expressed general satisfaction with the residences.

During the visits, the visiting teams received information and experiences which I can use in my further work both with visits and in relation to other initiatives to prevent torture and other cruel, inhuman or degrading treatment or punishment. I can mention the following examples:

During several visits, the visiting teams asked about the residences' collaboration with police, public prosecutor and psychiatric services. Generally, the collaboration was good, but some

residences experienced problems in getting the psychiatric service to assume responsibility for residents for whom the residences in specific situations did not feel able to take responsibility. One residence experienced similar problems in relation to the police. I will continue to pay attention to this issue.

Ringbo Residence Centre has a form for legal measures against sentenced residents. The form is completed in collaboration with the consultant responsible for the resident's treatment. The fields on the form are completed with name, civil registration number, the resident's address at Ringbo, date of completion, date of sentencing, maximum duration of the measure, maximum duration of hospital stay, name and place of employment of the responsible consultant, contact person at the Prison Service, Prison Service supervision, the measures implemented in relation to the resident pursuant to the relevant sentence, the employees' obligations/tasks pursuant to the relevant sentence and social security guardian. The form is a way of ensuring an overview of the effect of the sentence and the contact persons.

At some visits, the residences submitted copies of forms for registering violence and threats of violence against the employees. At Fuglekær Development Centre, the form for internal registration of threats and violence against employees was displayed on the notice board in the HR office with a ballpoint pen. At the top, the form has fields for recording residence and relevant resident. It then has a table for registering date, employee, resident and 1st, 2nd, 3rd, 4th, 5th and 6th degree. At the bottom is a note that the form is submitted every quarter to the Fuglekær administration, who send an overall registration to – now (I assume) – Vejle Municipality. A guide to the form explains that each episode is placed in one of various categories. If an episode consists of several types of assault (for instance both a verbal threat and a kick), it is placed in both categories. The guide then outlines what the six degrees cover. Threats and mental violence are divided into verbal threats, threatening behaviour, threats against the employee's family, "belittling" and hurtful comments, etc. (1st degree) and threats with body or objects (for instance threats with hand, foot, furniture, cutlery, etc.) (2nd degree). Physical violence is divided into physical violence with body (such as pinching, scratching, hair tearing, biting, kicking, slapping), stranglehold and immobilisation (3rd degree) and physical violence with objects (for instance furniture, cutlery, etc.) (4th degree). Finally, sexual malice is divided into verbal sexual comments and/or invitations, offers of sex and threats of rape (5th degree) and unwanted touching, fondling, indecent exposure, unconcealed masturbation, ejaculation, knocking over and attempted rape (6th degree). Fuglekær Development Centre has a similar form for internal registration of threats and violence between residents.

At least once a year, Østruplund carries out performance appraisals with the residents – so-called resident performance appraisals. Østruplund has written material about the appraisals (a plan and a concept for the appraisal and guideline questions for use during the appraisal).

The appraisal takes place before the annual action plan meeting and the conclusions of the appraisal are included in the action plan. During the appraisal, an employee asks the resident about wishes for the residence, work, leisure time, employees, family, friends and other subjects. The appraisal is a way of involving the resident.

At some visits, the residences and the visiting teams discussed the importance of the residents' right of self-determination in relation to the use of force and/or the social authorities' obligation to avoid dereliction of care.

At several residences, the residents were very different and for instance had different disabilities and needs.

All visits were concluded by notifying the residences that I had not received any information which gave me grounds for making comments to the responsible authorities.

