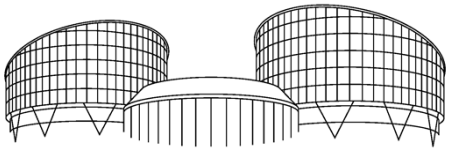

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

SECOND SECTION

CASE OF AGGERHOLM v. DENMARK

(Application no. 45439/18)

JUDGMENT

Art 3 • Inhuman and degrading treatment • Applicant's strapping to a restraint bed for almost twenty-three hours in a psychiatric hospital not strictly necessary and not respectful of his human dignity • Applicant suffering from paranoid schizophrenia and sentenced to a psychiatric hospital owing to criminal conviction for incidents of violence • Domestic courts' demonstration of the applicant's immobilisation as a matter of last resort and as the only means available to prevent immediate or imminent harm to others • Domestic courts silent on several issues crucial for the assessment of whether the continuation of the restraint, and its duration for almost twenty-three hours, was "strictly necessary" to prevent immediate or imminent harm to others

STRASBOURG

15 September 2020

This judgment will become final in the circumstances set out in Article 44 § 2 of the Convention. It may be subject to editorial revision.

In the case of Aggerholm v. Denmark,

The European Court of Human Rights (Second Section), sitting as a Chamber composed of:

Marko Bošnjak, *President,*
Jon Fridrik Kjølbro,
Valeriu Griţco,
Egidijus Kūris,
Arnfinn Bårdsen,
Darian Pavli,
Ivana Jelić, *judges,*

and Stanley Naismith, *Section Registrar,*

Having regard to:

the application against the Kingdom of Denmark lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a Danish national, Mr Niels Lund Aggerholm ("the applicant"), on 13 September 2018;

the decision to give notice to the Danish Government ("the Government") of the application;

the parties' observations;

Having deliberated in private on 7 July 2020,

Delivers the following judgment, which was adopted on that date:

INTRODUCTION

The applicant suffers from paranoid schizophrenia. After being convicted of various incidents of violence and threats of violence, he was sentenced to committal to a psychiatric hospital. There, on 8 February 2013, he was strapped to a restraint bed for approximately twenty-three hours. He complains that this measure was in breach of Article 3 of the Convention.

THE FACTS

1. The applicant was born in 1985 and lives in Aarhus. He was represented by Mr Tobias Jensen, a lawyer practising in Aarhus.

2. The Government were represented by their Agent, Mr Michael Braad, from the Ministry of Foreign Affairs, and their Co-Agent, Mrs Nina Holst-Christensen, from the Ministry of Justice.

3. In 1999 the applicant was diagnosed with paranoid schizophrenia.

4. On 28 June 2005 he was convicted under the Penal Code of five incidents of violence against a civil servant acting in his official function and threats of violence. He was sentenced to committal to a psychiatric hospital.

5. From 2007 to 2011 the applicant was in a high-security psychiatric unit under a so-called "dangerousness decree". Subsequently, he was treated

in an open psychiatric ward, but was moved to a closed ward, called P4, in September 2012.

6. On 3 January 2013, while in P4, the applicant was strapped to a restraint bed with a belt and wrist and ankle straps (also called a five-point restraint (*fempunktsfiksering*). The case before the Court does not concern that coercive measure.

7. On 8 February 2013 at 1.15 p.m. the applicant was once again strapped to a restraint bed with a belt and wrist and ankle straps, and he was restrained until 9 February 2013 at 12.05 p.m., thus for twenty-two hours and fifty minutes. The case before the Court concerns this coercive measure.

8. The applicant appealed to the Psychiatric Patients' Complaints Board (*det Psykiatriske Patientklagenævn*) in respect of both incidents when he had been restrained, and the board heard him on 19 March 2013.

9. H.H., the chief physician who had decided on the measures, had made a brief written statement on15 March 2013. Owing to illness, she could not attend the meeting before the board on 19 March 2013.

10. On 21 March 2013 the Psychiatric Patients' Complaints Board, basing itself on the applicant's written complaint and oral statement as well as H.H.'s written statement, found that both measures had been unlawful. It stated as follows:

> "The Psychiatric Patients' Complaints Board has reviewed the case and the statements made at the meeting. [The board] has found that the conditions for physical restraint with a belt and straps were not fulfilled.
>
> ...
>
> Concerning the [use of] physical restraint on 8 February 2013, the board has taken into account that you [the applicant] did not want to participate in a medical consultation with the doctor and that you have been described as very angry.
>
> Based on the above, the board has found that it has not been documented that you exposed yourself or others to an immediate risk of harm to body or health [*legeme eller helbred*]"

11. On 7 November 2013, referring to the decision of the Psychiatric Patients' Complaints Board, the applicant requested that the State Administration award him compensation for non-pecuniary damage. Additionally, he claimed that there had been a violation of Article 3 of the Convention.

12. On 5 December 2013 the State Administration dismissed the applicant's claim, finding that no violation of Article 3 of the Convention had occurred.

13. On 13 June 2014 the applicant lodged a complaint against H.H. with the Health Authority (*Sundhedsstyrelsen*) in respect of, *inter alia*, the measures of physical restraint at issue.

14. On 30 August 2014 H.H. made the following written statement to the Health Authority:

"While [the applicant] was in the psychiatric ward, restraint [measures were] used three times. ...

The second time that a restraint measure was used was on 8 February 2013, when [the applicant] had a lot of pent-up anger because [I] went against him because I insisted on telling him that he could not go on day release when he was so angry. I approached him three times; his anger remained the same, so I decide to use a restraint measure before anyone got hurt. That decision was declared unlawful by the Patients' Complaints Board.

The third time was when I decided to use a restraint measure in order to raise [the applicant's] clozapine treatment to an efficient level. The board accepted unanimously [that I was justified in doing so]. As a forensic psychiatrist, I must, of course, pursue the optimal treatment; however, I must also consider civil rights and due process considerations in my treatment, and I must make sure that I minimise the risk of recidivism. Reoffending will always prolong the time period during which a patient is treated in the forensic psychiatric system, and that is not to the advantage of either the patient or any of the victims."

15. On 19 December 2014 the Health Authority sent a letter to H.H., concluding as follows:

"... the Health Authority does not find grounds for deciding that you acted with a lack of care or conscientiousness."

16. In the meantime, on 20 June 2014 the applicant had brought an action before the City Court (*Retten i Roskilde*), claiming that the State Administration should acknowledge having violated his rights under Article 3 of the Convention and therefore pay him 50,000 Danish Kroner (DKK) or a lower amount determined by the court.

17. The applicant's daily records were submitted to the City Court. In so far as relevant, they included the following.

18. On 7 February 2013 at 7.38 p.m. (the evening before the measure of physical restraint at issue was applied) Doctor S.S. wrote:

"This evening, [the applicant] has been very frustrated and has expressed his anger and indignation about the treatment, in front of the group. This has led to other patients feeling insecure and the staff feeling abused ..."

On 7 February 2013 at 7.56 p.m. M.K., an educator (*pædagog*), wrote:

"[Description of what had happened between 5 and 6 p.m.] ... [the applicant] came into the dining room as the patient from room 6 sat talking loudly about his frustration about everything. [The applicant] made some negative comments. I asked him to stop, [but] he did not comply and continued [by saying] 'We need to do something about her [H.H.]'. I informed him that this could be understood as a threat and [the applicant] replied 'Go and write a lie.' ..."

On 7 February 2013 at 9.34 p.m. M.H.L., a social and healthcare assistant, wrote:

"From the beginning of the shift [the applicant] (and the other patient from his room) seemed negative and ready to argue about restrictions in the ward. My colleague heard [the applicant] make remarks about H.H., the chief physician, which could be understood as threats against her. See the note from 7.56 p.m. H.H. was

informed and she subsequently got in touch with the doctor on call, S.S., who had a conversation with [the applicant] afterwards, in the presence of my colleague. See the doctor's note.

After the conversation with the doctor [the applicant] seemed to be calm and quiet, and he made no further comments about the doctor or the staff or [demonstrated] frustration/anger towards them. ..."

19. The following day, on 8 February 2013 at 1.15 p.m. H.H. wrote:

"At the start of today, last night's situation was discussed among the staff. It was decided that it was not safe for [the applicant] to be allowed to go out on his own [only] accompanied by one of the staff when he was so angry. It was decided that he should be told about this and that his [medication] should be increased.

[The applicant] was asked to go into the consultation room. He did not want to sit down. [Still] standing, he leaned over the table and said that he did not want to talk to us. [The applicant] was very white in the face, his mouth was set in a straight line, and one sensed a lot of pent-up anger. [The applicant] walked out and I just managed to tell him that his [permission to go on] day release had been revoked.

We went after him with the aim of entering into a dialogue (*vi går efter mhp. at få en dialog i gang*) and [the applicant] said that we should not put him under pressure. This happened again at 11.30 a.m., and when we tried again later [the applicant] said that he did not want to talk to us and he did not want to be put under pressure.

After one and a half hours [the applicant] was still extremely angry, [and] we decided to summon the staff from Enggården, as [he] was considered to be dangerous to those around him. He was very angry, it was not possible to correct him, and the slightest approach seemed to provoke him severely.

Hence, it was decided that [the applicant] should be physically restrained with a belt, because of his dangerousness. He came to the belt room voluntarily and lay down on his own. ... I informed him that his behaviour made us afraid and that I had to increase his medication. ...".

20. At 3.30 p.m. the applicant's guardian [*bistandsværge*] was informed that the applicant had been restrained with a belt.

21. From the daily records it appears that throughout the period when the applicant was restrained there was always a social and healthcare assistant present with him. They regularly entered their observations in the daily records.

For example, on 8 February 2013 at 9.11 p.m. E.F., a carer, wrote that the applicant felt that he was being unfairly treated, but the tone of his voice was calm and quiet, and on 9 February 2013 at 6 a.m. M.O., another carer, wrote that the evening had been quiet and the applicant had slept throughout the night.

22. After the belt restraint measure had been implemented at 1.15 p.m., doctors checked on the applicant four times.

23. During the first check on the applicant at 2.45 p.m., H.H. tried to engage him in a dialogue. She decided that the applicant still had a great deal of pent-up anger and appeared to have some latent aggression.

24. There was a second check at 6.55 p.m., carried out by Doctor B.E., who noted that the applicant still did not comprehend why he had been restrained. He appeared to be more "quiet" and "talkative", and for that reason B.E. agreed to release one foot strap and to also release the applicant in connection with toilet visits and personal hygiene.

25. The third check on the applicant was at 10.46 p.m., and was carried out by B.E., who noted that the applicant had made progress but he was still potentially dangerous to other people because of his instinctive anger.

26. The following day, on 9 February 2013 at 10.30 a.m. B.E. checked on the applicant again. As the applicant was cooperative and had complied with all requests and instructions from the staff, B.E. assessed that it was safe to release him from the restraint bed. B.E. subsequently conferred with H.H., and it was decided that the applicant should be released at 12.05 p.m.

27. Before the City Court, the Medico-Legal Council (*Retslægerådet*) was consulted. On 2 June 2016 it stated the following:

> "... on the basis of the documents available, including the statement of 30 August 2014 from H.H., the chief physician, the Medico-Legal Council [observes] that since 1999 [the applicant] has been suffering from schizophrenia characterised by delusions. Because of violence in 2005, he was sentenced to placement in a psychiatric ward. In 2013 the High Court upheld the measure. From 2007 to 2011 [the applicant] was placed in the high-security psychiatric unit ... under a dangerousness decree. Subsequently, he was treated in an open psychiatric ward, but owing to [his] irritability and threatening behaviour, he was moved to a closed ward in September 2012. Afterwards, despite treatment with a potent anti-psychotic drug, [his] condition was described as fluctuating, with [the applicant having] a tendency to be aggressive [and] paranoid, and to overrate himself in an unrealistic manner. [The applicant had] no understanding of [his] illness, and his ability to have contact [with people] was compromised. ... On the evening of 7 February 2013 [the applicant] made threatening remarks about the chief physician responsible for the treatment. When she talked to him on 8 February 2013 he was completely dismissive, would not sit down, would not answer, and was white-faced and kept his mouth tightly shut, and he seemed to be affected by pent-up anger. Conversation with him was unsuccessful and, apart from being aggressive, he displayed a lack of logic, owing to [his] paranoid misinterpretation of hostility from the chief physician. He was considered to be dangerous, and at 1 p.m. the decision about physical restraints was made. Once he had the belt strapped around him he appeared to be very vocal and angry at first glance, but after a few hours he calmed down more, and consequently a foot strap was released and toilet visits were allowed. However, at around 11 p.m. he was still considered to be full of pent-up anger and potentially dangerous. At 12 noon on the following day he was released from the belt. The Medico-Legal Council must thus answer the given questions [as follows]:
>
> Question 1:
>
> *The Medico-Legal Council is asked to give a statement concerning the physical restraints applied to [the applicant] in the period from 3 January 2013 at 7.08 p.m. to 5 January 2013 at 3.15 p.m., and from 8 February 2013 at 1.15 p.m. to 9 February 2013 at 10.30 a.m. In this connection, the Medico-Legal Council is asked to assess whether the material conditions for physical restraints were present in relation to each incident.*

The Medico-Legal Council finds that the conditions for physical restraints were present in the given periods, as it was necessary to avoid [the applicant] subjecting others to an immediate risk of harm to body or health.

Question 2:

For each of the periods in question, the Medico-Legal Council is asked to state whether a sufficient assessment of the continued presence of the conditions for physical restraints was made, including whether [the applicant] was assessed with the required frequency.

The Medico-Legal Council finds that during the periods when [the applicant] was restrained, medical assessments were made with the required frequency to assess if the conditions for the restraint continued to be present.

Question 3:

For each of the periods in question, the Medico-Legal Council is also asked to state whether the assessment of the continued presence of the conditions for physical restraints made by the chief physician could give grounds for the chief physician being blamed for reckless treatment, or if the responsible doctor was justified in assessing that the conditions for physical restraints were present in the above-mentioned periods.

The Medico-Legal Council finds that the chief physician's assessment of the conditions for physical restraints was correct, and thus that the chief physician's assessment was justified.

Question 4:

For each of the periods in question, the Medico-Legal Council is asked to state whether the case gives grounds for any other comments from the Medico-Legal Council and, if so, which?

No."

28. Before the City Court, the applicant, the chief physician H.H., and two social and healthcare assistants were heard.

29. The applicant stated, among other things:

"... in general, there were major problems with H.H. She was keen on using power and, almost from day one, she took away my day release, and instead of staying in the ward for a month I ended up staying one and a half years. There was to be a meeting between me and H.H. ..., [who] made me anxious ... She informed me that my [permission to go on] day release had been revoked. I went back, sat down, and continued eating. I was asked to come back to the meeting, but I refused. I wanted to make a call from a phone box. I wanted to talk to M. and my mother. Suddenly, ten people were outside and I was told that I was going to be restrained by a belt, which happened subsequently. The physical restraint was [employed] as usual. I knew that I should stay calm and quiet and then I would get justice later. I did not utter any threats ..."

30. H.H., the chief physician, explained that she had worked in psychiatry since 1983. In November 2012 she had become the chief physician at P4 (the closed ward where the applicant had been placed).

"On 7 February 2013, the previous evening, the staff had called me on the phone. This was because [the applicant] had once again been very angry. He had made

threats against me personally and had been very abrasive towards the staff. During patient rounds the following day, it was discussed whether [he] should be allowed to go on day release outside the ward. It was decided that he should not be granted permission to go on day release, as he had so much anger inside him. As the chief physician responsible, I had to tell [the applicant] that he would not go on day release. [The applicant] did not want to speak to me, but I had to inform him that there would be no day release [for him]. [The applicant] became extremely angry. He seemed to have a lot of pent-up anger and seemed aggressive. [The applicant] was in his room and I left the room to give him a time-out. This was in order to avoid my presence increasing his aggression. However, his aggression and tension was building up to such an extent that I did not dare to [leave] him [un]restrained by a belt. I feared that [everything] would go terribly wrong and escalate into violence, and that someone would get hurt. I decided that there was a significant risk of [the applicant] resorting to violence, and there was also [the applicant] himself to consider, so that there would not be a risk of him ending up assaulting someone else. The threats against me were 'We have to do something about her'. [The applicant] had said this and the staff had perceived this to be threats against me. I knew that [the applicant] did not like me. [He] had a lot of anger inside him which was directed against me, and the threat might mean that there was a risk of me being assaulted. I already knew the details of the course of [the applicant's] illness and treatment over the years, and I knew that [he] had previously assaulted staff and other patients in psychiatric wards, which was, in part, what he had been sentenced for. Among other things, there had been an aggravated assault on a carer. Thus, I knew that [the applicant] might react violently if he was feeling bad.

I have since decided that in the period January to February [2013] [the applicant] was probably not correctly medicated. It is likely that there was a failure in the medication at the beginning of 2013. In March 2013 I applied for permission to increase [his] dosage, which was given. It is probable that [the applicant] did not receive sufficient medical treatment until the summer of 2013. It was also problematic that there was some medicine that he did not tolerate, and that he might not have been taking everything. From the summer of 2013 onwards and in the following months there was a decisive improvement, after the medication had been increased.

I was ill on the day when the Patients' Complaints Board dealt with [the applicant's] complaint. Hence, I did not come to the meeting of the Patients' Complaints Board. To assist the board with that procedure, I had made a statement, although it was a very brief statement. I heard from a nurse who was present [at the meeting] that [the person] who attended the meeting with the board on behalf of the psychiatric hospital did not say anything, so [the applicant's] version of the events was unchallenged. If I had been present, I would have had an opportunity to elaborate on my rather brief statement.

I no longer work at P4. I am now employed at ... Being presented with [the applicant's] statement about [me] being power-hungry, I would say that I am very aware of the power given to me as the treating chief physician. I have always tried to manage this in a proper way.

A major characteristic of the history of [the applicant's] illness has been his difficulty to relate to being ill and needing help ... In general, [the applicant] was very angry at the system. ... [for continued physical restraint, the issue of whether the person in question has insight into the course of the events] is not [decisive, what is decisive is the danger]. The danger must have ended before the restraints are released. It was not the first time in the course of [the applicant's] illness that people had been very afraid of him and he had had no understanding of it. It is also all right to be angry, and that,

in itself, cannot lead to physical restraint. I also understand that one can be angry about the situation. However, when the anger is of such a nature and extent that there is a fear that someone will be hurt, you must physically restrain a patient. Before this happens, there is a time when you try to talk to the person in question and try to avert the anger. Physical restraint is a last resort in order to calm the situation, and only if no other measure is possible. It is also all right that a patient and a doctor have different opinions on a course of events. This is not, in itself, a reason for continued restraint. ...

On 8 February 2013 when I was at work there was an immediate risk to others, and that was the reason for deciding to use physical restraint. Of course, I also had [the applicant] himself in mind and the fact that he should be prevented from using violence against other people. Physical restraint is not a treatment measure. Physical restraint only happens when you cannot use other measures and when you are afraid that something serious will happen if you do not use it. [The applicant's] behaviour was seriously aggressive, threatening and worrying. It was his body language and attitude. When [the applicant] was so angry, the wrong remark might easily have led to [him] using physical violence. This is also the reason why I chose to walk away as a kind of time-out when I had informed him that he would not go on day release. When I returned to him one and a half hours later his fierceness and aggression had not changed, and the smallest remark could result in the risk of physical violence. I am also entirely sure that [the applicant] was offered a sedative before being physically restrained with the belt."

31. M.H.L., a social and healthcare assistant, explained:

"... I was also working on 7 and 8 February 2013. I remember that [the applicant] was very angry with the chief physician. He believed that everything was her fault. He made remarks about her being an idiot and [said] that she should have 'a bullet through her head'. I also heard him say directly 'We have to do something about her'. I wrote the remarks down in the medical record and also contacted the chief physician. [The applicant] seemed very convinced when he said that something should be done about her. It would usually be like this when he had those thoughts, and then he would be completely convinced that this was the way it should be. The decision about physical restraint itself was made by the doctor. Other colleagues apart from myself heard [the applicant] say on 7 and 8 February 2013 that the chief physician should have a bullet through her head and that someone should do something about her. I interpreted this as meaning that [the applicant] wanted to get at the chief physician, not that she should be fired."

32. The other social and healthcare assistant who testified before the City Court gave an explanation about the incident on 3 January 2013.

33. On 24 March 2017 the City Court found against the applicant. It stated as follows:

"It appears from section 14(2)(i) of the Act on the Use of Coercion in Psychiatry – see the wording of Act no. 1729 of 2 December 2010 applicable at the time of the decision made by the Patients' Complaints Board on 21 March 2013 – that physical restraint can only be used to the extent necessary in order to prevent a patient from exposing himself or others to an immediate risk of harm to body or health.

In accordance with section 4(2) of the Act, the use of coercion must be proportionate to the purpose sought [through the use of that coercion]. If less intrusive measures are sufficient, they must be used.

It appears from the statement made to the Health Authority by H.H., the chief physician, on 30 August 2014 that ... [see paragraph 14 above]

It further appears from the statement that on 8 February 2013 [the applicant] had a lot of pent-up anger because the chief physician had gone against him and insisted on telling him that he could not go on day release while he was so angry.

It appears from the letter of 19 December 2014 from the Health Authority that the authority stated that there was no basis for assuming that the chief physician had acted negligently or with a lack of conscientiousness.

...

It appears from the medical records of the evening of 7 February 2013, among other things, that [the applicant] was described as very frustrated and he expressed his anger and indignation about the treatment in front of the group. The patients felt insecure and the staff felt abused. Further, it appears that later on [the applicant] said 'We have to do something about her'.

It appears from the medical records of 8 February 2013 that he did not want to sit down in the interview room. 'His face was white, his mouth was set in a straight line, and one sensed a lot of pent-up anger'. Dialogue was not possible. After one and a half hours he was still very angry and unable to modify his behaviour. As regards the applicant's mental state, he was assessed as 'having mental capacity, objectively speaking. [He was] alert and awake, paranoid with an inverted [sense of] logic, very angry, with latent aggression, and threatening.'

It further appears from the medical records that he continued to be very angry and vocal while he was restrained by the belt. At 2.45 p.m. it was noted that 'a lot of pent-up anger and feelings of injustice appeared, [the applicant] seemed to be seriously deteriorating and had latent aggression'. The foot strap was released after a few hours and visits to the toilet were permitted. At around 11.00 p.m. it was decided that he was still potentially dangerous to other people and [still] had pent-up anger. After a conversation with the doctor on 9 February 2013 he was assessed as being calm and cooperative, and he was freed on the same day at 12.05 p.m.

...

Concerning the course of the events leading up to the use of physical restraint on 7 February 2013, the witness [H.H.] stated, among other things, that there had been threats against her personally from [the applicant] and he had been very abusive towards the staff. [The applicant] was seriously angry; he seemed to have a lot of pent-up anger and was very aggressive. His aggression and tension were of a nature which caused the witness to fear that [everything] would go terribly wrong and escalate into violence and that someone would get hurt. The witness decided that there was a significant risk of [the applicant] resorting to violence. The witness stated that she already had a detailed knowledge of the course of [the applicant's] illness and treatment over the years, and she knew that [he] had previously assaulted staff and other patients in psychiatric wards, which was, in part, what he had been sentenced for. Among other things, there had been an aggravated assault on a carer. Thus, she knew that [the applicant] might react violently if he was feeling bad.

...

Likewise, on 8 February 2013 there was, according to H.H., the chief physician, a course of events leading up to the physical restraint, during which time she tried to withdraw in order not to increase [the applicant's] aggression.

> Furthermore, on the basis of the medical records [and] the statements of M.H.L. and the chief physician H.H. about [the applicant's] behaviour in the course of the events leading up to and during the two instances of physical restraint, together with the Medico-Legal Council's statement, the court considers that the instances of physical restraint and the duration [of those instances] were necessary in order to avoid [the applicant] subjecting others to an immediate risk of [harm to] body or health.
>
> Consequently, [the State Administration] has documented that the conditions under section 14(2)(i) of Act no. 1729 of 2 December 2010 on [the Use of] Coercion in Psychiatry were fulfilled for both the instance of physical restraint from 3 January 2013 to 5 January 2013, and the instance of physical restraint from 8 February 2013 to 9 February 2013, and likewise it has been documented that measures less intrusive than physical restraint were not possible, see the principle of the least intrusive measure in section 4 of the Act."

34. The applicant appealed against the judgment, but only in respect of the instance of restraint on 8 February 2013.

35. By a judgment of 9 November 2017 the High Court of Eastern Denmark (*Østre landsret*) approved the measure whereby the applicant had been restrained, finding that there were no reasons to disregard the chief physician's assessment at the time of the incident, that it had been necessary to strap the applicant to a restraint bed in order to avoid an imminent risk to others, and that while he had been restrained the staff had assessed with sufficient frequency whether the conditions for keeping him restrained were still present. In particular, the court stated:

> "... Based on the information before it, including the statement from the Medico-Legal Council, the High Court finds no reasons to overrule the chief physician's assessment, according to which it was necessary to physically restrain [the applicant] to prevent him from subjecting other people to an immediate risk of harm to body or health. Based on the same, the High Court finds that while [the applicant] was physically restrained, medical evaluations were made with sufficient frequency to assess whether the conditions for the measure were still present. Hence, the physical restraint of [the applicant] with a belt as well as wrist and foot straps from 8 February 2013 at 1.15 p.m. to 9 February 2013 at 10.30 a.m. was legal under section 14 of the Act on the Use of Coercion in Psychiatry."

36. Leave to appeal to the Supreme Court (*Højesteret*) was refused on 15 March 2018.

37. In the meantime, on 12 April 2016 the High Court had found that the applicant's sentence could be changed to treatment at a psychiatric hospital (instead of committal), with the possibility of hospitalisation if the chief physician made a decision in this regard.

38. On 10 December 2018 the High Court revoked the applicant's sentence.

RELEVANT LEGAL FRAMEWORK AND PRACTICE

39. The relevant provisions regulating the use of compulsion in psychiatry are set out in the Act on the Use of Coercion in Psychiatry (*Lov*

om anvendelse af tvang i psykiatrien), hereafter "the Mental Health Act" (*Psykiatriloven*). At the relevant time, section 4 provided for the overall framework, and read:

Section 4

"1. Compulsion must not be used until everything possible has been done to obtain the patient's voluntary participation. When conditions allow for this, the patient shall have an appropriate reflection period.

2. The use of compulsion shall be proportionate to what is sought to be achieved by [the use of compulsion]. If less restrictive measures are sufficient, these must be used.

3. Compulsion shall be used as sparingly as possible and with maximum consideration for the patient, so that there is no unnecessary violation or inconvenience.

4. Compulsion must not be used to a greater extent than is necessary to achieve the purpose which is sought.

5. After the cessation of any compulsory measure, the patient shall be offered one or more consultations. The Danish Health Authority is authorised to determine rules in this regard."

40. The preparatory notes to section 4 (*Betænkning* no. 1109/1987) set out:

"To ensure that compulsion is not used until all means of obtaining the patient's consent have been exhausted, section 4(1) provides that the patient's consent shall be sought and that, apart from in acute situations, the patient shall be given an appropriate reflection period in order to take a position on this issue. This may, *inter alia*, entail encouraging the patient: to let himself be admitted voluntarily; to voluntarily submit to treatment; or to voluntarily refrain from showing a specific type of behaviour.

If encouraging the patient to participate voluntarily is unsuccessful and the use of compulsion is considered – provided that the conditions for [the use of compulsion] are present – 'the principle of the least intrusive measure' applies, which shall be observed in connection with any use of compulsion. This specific formulation of the principle of proportionality would apply without any explicit provisions in this regard, but the [drafting] committee, by codifying the rules [which provide] that compulsion must not go beyond the scope of the purpose [sought], and that compulsion in itself must be proportionate to what is sought to be achieved by the [use of] compulsion, wished to underline the importance of compliance with this principle, so that the use of compulsion under this Act is limited to what is strictly necessary. Reference is made to section 4(2) to (4).

In contrast to the above, the committee considered it superfluous to codify [provisions setting out] that the use of compulsion and force must not be used to punish patients, just as degrading and humiliating treatment is prohibited. When compulsion must be used as sparingly as possible and without causing unnecessary violation or inconvenience, this means that punitive measures and degrading treatment are all the more prohibited, see section 4(3). Patients have a right to be treated equally as fellow human beings, and with all the consideration that their mental illness also requires."

41. More detailed requirements for the use of restraint are set out in sections 14 to 16 of the Mental Health Act:

Section 14

"1. Only belt[s], wrist and ankle straps and hand control mittens shall be used as measures of compulsory restraint.

2. Compulsory restraint must only be used to the extent that it is necessary to prevent a patient:

i) from exposing himself or others to an imminent risk of harm to body or health,

..."

Section 15

"1. Decisions to use compulsory restraint must be made by a doctor after [he or she] has checked on the patient.

2. A decision on whether to use wrist or ankle straps in addition to a belt shall, however, be made by the chief physician.

3. If, in the event of a situation covered by section 14(2)(i), it would be unsafe to await the doctor's examination, on account of the patient's own safety or the safety of others, the healthcare staff may decide on their own to restrain the patient in question. The doctor shall then be summoned immediately and make a decision as regards the use of compulsory restraint by a belt."

Section 16

"A patient who is restrained by a belt shall have somebody keeping a constant watch [over him or her]."

42. The preparatory notes to section 14 (Bill L76, submitted on 26 October 1988) set out:

"Section 14(1) provides an exhaustive list of the measures that are allowed for compulsory restraint when the conditions of subsection 2 are met. No other compulsory measures – other than belt[s], wrist and ankle straps and hand control mittens – may be used.

If, on the grounds mentioned in section 14(2), it is decided that it is necessary to use a belt made out of leather or fabric, the procedure under section 15 involving prior instructions [from a doctor] shall be followed in every case. This applies to all patients who are admitted to a psychiatric ward ...

Section 14(2) provides for the substantive circumstances under which compulsory measures may be used.

Subsection 2(i) [covers] the most serious cases of imminent risk of harm to body or health ... [and] the largest group of protected persons is provided for here. The rule covers not only restraints used with a view to protecting fellow patients, but also [those used] to protect staff, visitors and all other people who frequent the ward, as well as the patient himself or herself. The rule thus provides the legal basis for intervention in cases of self-destructive behaviour.

The criterion [for the use of restraint] is danger. For a danger to be considered imminent, it must be specific, present and demonstrable. Danger manifesting itself in destructive actions is not a prerequisite for intervention."

43. The preparatory notes to section 14 (*Betænkning* no. 1109/1987) set out, *inter alia*:

"...

The criterion is danger. For a danger to be considered imminent, it must be specific, present and demonstrable. However, a latent danger that may manifest itself under certain conditions or circumstances that may occur later will not suffice."

44. Under the Mental Health Act, the Danish Health Ministry adopted supplementary rules about compulsory restraint in Act no. 1338 of 2 December 2010 on the use of other kinds of compulsion other than deprivation of liberty in psychiatric wards, such as:

Section 19

"...

3. Prior to the specific use of compulsory restraint, there must be instructions [from a doctor] after the doctor has checked on the patient.

4. It is a prerequisite for the instructions [from the doctor] that the doctor, on the basis of the patient's present condition, has decided that compulsory restraint is necessary and that the use of other measures, for example increased supervision, has proved to be insufficient or impossible as a consequence of the patient's condition.

5. A decision on whether wrist or foot straps shall be used in addition to a belt shall be made by the chief physician. In the absence of the chief physician, the decision can be made by another doctor. In such cases, the chief physician shall subsequently review the decision as soon as possible.

..."

Section 21

"1. A patient who is restrained by a belt shall have somebody keeping a constant watch [over him or her].

2. [A person] keeping a constant watch is a nurse, a carer, or some other qualified staff member put in charge of the situation who does not simultaneously have other work tasks other than caring for the patient or patients restrained by a belt.

3. The supervision shall be carried out with attention to the patient's wishes and with respect for his or her dignity and self-esteem.

4. The patient shall have a right to a certain degree of private life, when this is not incompatible with the patient's safety."

Section 22

"...

4. If, in the case of compulsory restraint, mittens, [or] wrist or foot straps are used, in addition to a belt, the assessments under subsection 1-3 must include a separate assessment of the continued use of these coercive measures.

...

9. However, it is always up to the nursing staff to put an end to [the use of] coercion when there is no longer any need to maintain it."

45. Various provisions in the Mental Health Act concern the registration and supervision of compulsory restraint:

Section 20

"1. Information on any use of compulsion, see sections ... 14 to 17 a ..., shall be noted in the ward's record on [the use of] compulsion, [and] the specific characteristics [of the intervention] and the reason for the intervention shall be indicated. This applies to all instructions under section 18.

2. The Minister of the Interior and Health determines the specific rules on records on [the use of] compulsion, as well as the registration and reporting of [the use of] compulsion to the hospital authority and the Danish Health Authority. In that connection, the Minister of the Interior and Health may determine that the reports shall contain information about the patient's identity.

..."

Section 21

"1. The chief physician is continuously responsible for ... compulsory restraint ... not being applied to a greater extent than is necessary.

...

4. As long as a compulsory restraint is continued, the medical assessment of the continued use of the compulsory restraint shall be reviewed as often as the conditions allow, but at least four times every 24 hours, which should be evenly spread out, after the decision about the use of the compulsory restraint has been made.

..."

46. The requirements for registering the use of a restraint measure are elaborated on in administrative practice note no. 9713 of 20 December 2011 on the completion of records on the use of compulsion (the registration of the use of compulsion in the psychiatric system, including the registration of measures in respect of minors) and the registration of the use of discharge agreements/coordination plans; they state, among other things:

"2.3. Restraint and the use of straps

The date and time of the initiation and cessation [of a measure of restraint] must be entered.

The cessation of restraint by a belt is understood [to mean] that the belt has been released for a longer time than just a short while. If the belt is temporarily released for up to one hour, this must not be registered.

The name of the prescribing doctor and the staff involved must be entered in the records.

As regards the supplementary use of straps, this compulsory measure shall be recorded [taking into account the relevant period of time] as a whole, with the start time indicated as the time when the first strap is fastened, and the end time being when the last strap has been released.

Where straps are employed in the use of compulsion, the name of the chief physician shall be entered [in the records]. Simultaneous restraint by a belt and the use of straps shall be entered in the same form, as the use of straps is regarded as a supplement to the restraint.

A reason, as specified in section 14 of the Danish Mental Health Act, must be entered in respect of any compulsory measure.

If the decision about the use of straps is made by another doctor in the absence of the chief physician, the date of the chief physician's subsequent position [on the use of straps] must be entered.

In connection with the medical assessment four times a day of the continuation of the compulsory restraint, the time [of the assessment] and the doctor's initials shall be entered. The assessment shall be noted in the daily records."

47. Various provisions of the Mental Health Act concern the complaints procedure for and judicial review of compulsory restraint.

Section 34

"1. As part of every State Administration, a Psychiatric Patients' Complaints Board shall be established, consisting of the State Administration's Director as the chairman (see, however, subsection 2) and two board members. The Minister of the Interior and Health appoints a number of members upon recommendations from the Danish Medical Association and the Danish Disabled People's Organisations. The Minister of the Interior and Health also appoints deputy members. Appointments last a period of four years, and [individuals may be] reappointed.

2. The Director of the State Administration may authorise employees of the State Administration to act as Chairman of the [Psychiatric Patients' Complaints] Board.

3. The State Administration performs the secretarial tasks of the Psychiatric Patients' Complaints Board and bears the operating costs of the board, including [the costs of] remunerating the members of the board."

Section 35

"Hospital authorities shall, at the request of a patient or patient counsellor, submit complaints about compulsory admissions, compulsory detention, retransfers, compulsory treatment, compulsory follow-ups after discharge under section 13 d, compulsory restraint, the use of physical force, protective restraint, the use of personal alarm and tracking systems and specific door locks, personal shielding lasting more than 24 consecutive hours, the locking of doors in the ward, compulsory restraint while a person is ambulatory, and the locking of the patient's room in the high-

security psychiatric unit (HDU) (*Sikringsanstalten*) under the Zealand region's forensic psychiatric ward, to the Psychiatric Patients' Complaints Board at the State Administration."

Section 36

"1. When a case like those mentioned in section 35 is brought before the Psychiatric Patients' Complaints Board by the State Administration, the hospital authorities shall forward the documents relating to the case, including a written record of the compulsory measure and a statement from the chief physician. Furthermore, the board shall itself determine the facts of the case and decide on whether to obtain additional statements and so on, and the board may visit the psychiatric ward of the patient in question.

2. The patient and the patient counsellor have a right to orally present the case to the board. In exceptional cases, where the patient's health or the case proceedings before the board decisively warrant this, the board may decide that the patient should be fully or partially excluded from participating in the proceedings.

...

4. The Minister for Health and Affairs relating to the Elderly determines the rules of procedure for the Psychiatric Patients' Complaints Boards at the State Administration."

Section 37

"The Psychiatric Patients' Complaints Board at the State Administration shall, at the request of the patient or the patient counsellor, bring its decisions as regards ... compulsory restraint ... before the courts, pursuant to the rules of the Danish Administration of Justice Act chapter 43 a.

..."

48. The rules on the tasks of the Medico-Legal Council and its composition appear in Act no. 60 of 25 March 1961.

Section 1

"The task of the Medico-Legal Council is to make medico-forensic and pharmaceutical assessments for public authorities for the purposes of cases concerning the legal circumstances of individuals. The Minister of Justice may lay down detailed rules determining the authorities that can ask the council to make an assessment and the cases in which such assessments can be requested."

Section 2

"The council is comprised of up to 12 physicians. The council has two divisions, one of which focuses on forensic psychiatric issues, and the other [which focuses] on all other medico-forensic issues. ..."

49. The Government have provided the following statistical overview of the use of physical restraint in Denmark.

50. Table 1 shows the prevalence of the use of restraint by a belt and the duration of instances of restraint for each year for the period from 2010 to

2018. The numbers indicate the number of times restraint by a belt was used in the psychiatric system. If a psychiatric patient was restrained by a belt several times in one year, every instance of restraint by a belt is indicated as a separate incident. The table covers only persons who were nineteen years or older at the time when the restraint by a belt was initiated.

	2010	2011	2012	2013	2014	2015	2016	2017	2018
0-3 hours	945	849	1,039	974	735	879	840	899	815
3-12 hours	1,507	1,497	1,426	1,554	1,411	1,401	1,300	1,261	1,036
12-24 hours	958	1,061	1,098	1,060	1,016	1,024	975	809	788
24-48 hours	551	657	712	743	672	533	496	344	391
48+ hours	545	639	756	844	775	530	491	439	444
Total	4,508	**4,704**	**5,035**	**5,182**	**4.617**	**4.379**	**4.137**	**3,756**	**3,478**

Source: The Danish Health Data Authority

51. Table 2 shows the development for the period 2010 to 2018 in the number of persons admitted to psychiatric hospitals and the number of psychiatric admissions. "Persons admitted" covers the number of persons who were admitted to a psychiatric hospital once or several times in a given year. "Admissions" covers each single period of hospitalisation, as the same person might have been hospitalised several times in one year.

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Persons admitted	23,029	23,224	23,749	24,191	24,224	23,875	23,213	23,658	24,052
Admissions	44,984	47,017	47,909	49,000	48,968	48,485	46,811	48,692	49,304

Source: The Danish Health Data Authority

52. As indicated in tables 1 and 2 above, in 2013 there were 49,000 admissions to psychiatric hospitals and 5,182 instances of restraint by a belt. Thus, on average, in 2013 restraint by a belt was used in approximately 10.6% of all hospitalisation cases.

RELEVANT INTERNATIONAL AND EUROPEAN MATERIAL

53. The relevant provisions of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (A/RES/46/119, 17 December 1991) read:

Principle 1
Fundamental freedoms and basic rights

"...

2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person."

Principle 9
Treatment

"1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

...

3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.

..."

Principle 11
Consent to treatment

"...

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient."

54. In its report of 4 February 2016 regarding Denmark, the United Nation's Committee Against Torture (CAT/C/DNK/CO/6-7) stated, among other things:

"40. The Committee is concerned at the frequent recourse to coercive measures, often accompanied by immobilisation of patients, in psychiatric institutions, in spite

of the fact that the [mental health Act] stipulates that they should be used as a last resort ...

41. The State party should:

(a) Ensure that every competent mental health patient, whether voluntary or involuntary, is fully informed about the treatment to be prescribed, and given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law;

(b) Revise and tighten regulations with clear and detailed guidance on the exceptional circumstances where the use of restraints may be allowed, with a view to considerably decreasing the recourse thereto in mental health care."

55. The relevant parts of Recommendation Rec(2004)10 of the Committee of Ministers of the Council of Europe to member States concerning the protection of the human rights and dignity of persons with mental disorders, 22 September 2004, read as follows:

Article 27

"1. Seclusion or restraint should only be used in appropriate facilities, and in compliance with the principle of least restriction, to prevent imminent harm to the person concerned or others, and in proportion to the risks entailed.

2. Such measures should only be used under medical supervision, and should be appropriately documented.

3. In addition:

i. the person subject to seclusion or restraint should be regularly monitored;

ii. the reasons for, and duration of, such measures should be recorded in the person's medical records and in a register.

4. This Article does not apply to momentary restraint."

56. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) standards (CPT/Inf/E (2002) 1- Rev. 2010) contain the following rules on restraining patients in psychiatric establishments:

"Involuntary placement in psychiatric establishments

Extract from the 8th General Report [CPT/Inf (98) 12]

47. In any psychiatric establishment, the restraint of agitated and/or violent patients may on occasion be necessary. This is an area of particular concern to the CPT, given the potential for abuse and ill-treatment.

The restraint of patients should be the subject of a clearly-defined policy. That policy should make clear that initial attempts to restrain agitated or violent patients should, as far as possible, be non-physical (e.g. verbal instruction) and that where physical restraint is necessary, it should in principle be limited to manual control.

Staff in psychiatric establishments should receive training in both non-physical and manual control techniques vis-à-vis agitated or violent patients. The possession of such skills will enable staff to choose the most appropriate response when confronted

by difficult situations, thereby significantly reducing the risk of injuries to patients and staff.

48. Resort to instruments of physical restraint (straps, strait-jackets, etc.) shall only very rarely be justified and must always be either expressly ordered by a doctor or immediately brought to the attention of a doctor with a view to seeking his approval. If, exceptionally, recourse is had to instruments of physical restraint, they should be removed at the earliest opportunity; they should never be applied, or their application prolonged, as a punishment ...

...

50. Every instance of the physical restraint of a patient (manual control, use of instruments of physical restraint, seclusion) should be recorded in a specific register established for this purpose (as well as in the patient's file). The entry should include the times at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff.

This will greatly facilitate both the management of such incidents and the oversight of the extent of their occurrence."

The following extract on means of restraint in psychiatric establishments for adults, from the 16th General Report (CPT/Inf (2006) 35), reads:

"43. As a general rule, a patient should only be restrained as a measure of last resort; an extreme action applied in order to prevent imminent injury or to reduce acute agitation and/or violence ...

...

52. Experience has shown that detailed and accurate recording of instances of restraint can provide hospital management with an oversight of the extent of their occurrence and enable measures to be taken, where appropriate, to reduce their incidence.

Preferably, a specific register should be established to record all instances of recourse to means of restraint. This would be in addition to the records contained within the patient's personal medical file. The entries in the register should include the time at which the measure began and ended; the circumstances of the case; the reasons for resorting to the measure; the name of the doctor who ordered or approved it; and an account of any injuries sustained by patients or staff. Patients should be entitled to attach comments to the register, and should be informed of this; at their request, they should receive a copy of the full entry."

57. The CPT has visited Denmark on several occasions and made specific statements about the use of physical restraint in prisons and psychiatric establishments.

58. In its report from 2002 (CPT/Inf (2002)18), the CPT expressed concern about the physical restraint of patients and recommended that it be reviewed as a matter of urgency (see paragraphs 75-76 of the report).

59. In its report from 2008 (CPT/Inf (2008)26), the CPT expressed concerns, notably about the use of long-term physical restraint at the high-security psychiatric unit in Nykøbing Sjælland (*Sikringen*), which receives patients who are considered too dangerous to be placed in other

closed forensic or civil wards in Denmark. The CPT stressed that means of restraint should only be used as a last resort to prevent the risk of harm to the individual or others, and only when all other reasonable options would fail to satisfactorily contain that risk, and that the duration of the application of means of mechanical restraint should be for the shortest possible time (usually for minutes or a few hours) (see paragraphs 124-127 of the report).

60. In its response (CPT/Inf (2009)12), the Danish Government did not find that there were grounds for introducing a time-limit for the application of physical restraint, "as this might deprive psychiatric departments and staff of the means to undertake necessary measures for the protection of the patient concerned and other patients, should the patient's condition be unaltered at the expiry of the time limit". They further submitted that the nursing staff could at any time discontinue physical immobilisation without a doctor's prior assessment when restraint was no longer deemed necessary (see page 48 of the response).

61. In its report from 2014 (CPT/Inf (2014)25), subsequent to its visit from 4 to 13 February 2014, the CPT stated, among other things:

> "121. As regards the use of immobilisation in psychiatric hospitals, the CPT's delegation noted a constructive attitude among its interlocutors, and an overall acknowledgement both by the central authorities and the staff in the hospitals visited of the need to reduce the resort to immobilisation (and coercion in general). However, despite measures taken to tackle the frequent use and length of immobilisation in psychiatric hospitals, such as increased staff training and certain legislative amendments, there had been no reduction in the registered use of immobilisation in Denmark. On the contrary, the instances of immobilisation, and notably those of prolonged immobilisation (for more than 48 hours), has steadily increased and reached all-time peaks in 2012 and 2013 on a national level. The CPT therefore remains seriously concerned about the frequent and prolonged use of immobilisation in psychiatric hospitals. ...
>
> In the CPT's view, the duration of the actual means of restraint should be for the shortest possible time (usually minutes to a few hours), and should always be terminated when the reason for the use of restraint has ceased. The maximum duration of the application of mechanical restraint should ordinarily not exceed 6 hours. As pointed out in the reports on the CPT's 2002 and 2008 visits to Denmark, the Committee considers that applying instruments of physical restraint to psychiatric patients for days on end cannot have any medical justification and amounts to ill-treatment.
>
> 122. According to Section 15 of the Mental Health Act, immobilisation is as a rule to be decided by a doctor. Only in emergency situations could a patient be restrained to a bed with an abdominal belt upon the authorisation of a nurse while the doctor has to be called immediately. During immobilisation, one staff member has to be permanently located near the patient (while as far as possible respecting his/her privacy). The need for continuation of the measure of immobilisation has to be medically assessed at least four times a day in evenly-spaced intervals by a doctor. A second doctor has to authorise the continuation of immobilisation beyond 48 hours; however, such authorisation is thereafter obligatory only once a week. In the Committee's view, a restraint approval based on the patient's physical and mental condition is of little value if it is several days old. Moreover, the documentation

examined by the delegation showed that in the case of a patient who had been continually immobilised for a period of 34 days at *Amager*, authorisation in writing by a second doctor had only been provided twice during the whole period. Indeed, staff was of the opinion that only one such authorisation was required, even if the patient was restrained for more than a month. Existing legal safeguards must be rigorously enforced.

123. The second doctor's authorisation was usually provided by a psychiatrist from a different ward within the same hospital. In case of disagreement between the treating and the second doctor as to the need for continuing the immobilisation, the law provides that the treating doctor's opinion prevailed. In the Committee's view, such a disagreement is a serious matter and should automatically lead to a referral to a third authority for a decision. An independent scrutiny should not rely on the second doctor's or the patient's ability and willingness to appeal.

124. The release of an immobilised patient from belt restraint could be authorised by a nurse without consulting a doctor. This is positive, as it helps avoid the measure lasting longer than is absolutely necessary.

However, the legislative amendments do not explicitly stipulate that the application of immobilisation should stop as soon as the danger of harm has passed and no maximum duration for immobilisation has been introduced. From the documentation examined, the delegation found that patients were frequently immobilised for 47 hours. The frequent termination of immobilisation just before the requirement for the second doctor's assessment may raise questions as to the genuine necessity of applying the measure for the whole 47 hours. Moreover, at *Amager*, staff told the delegation that the release of a patient from immobilisation depended *inter alia* on the situation on the ward, such as the presence of other particularly demanding patients, staffing levels and the female/male staff ratio on the shift. Such a state of affairs, if accurate, would not be acceptable.

125. The CPT again calls upon the Danish authorities to review the legislation and practice of immobilising psychiatric patients and in particular to ensure that immobilisation with a belt:

- is only used as a last resort to prevent risk of harm to the patient or to others;

- is applied for the shortest possible time (usually minutes rather than hours) and is always terminated as soon as the danger of harm has passed; the maximum duration should ordinarily not exceed six and under no circumstances exceed 24 hours;

- is never applied or its application prolonged due to a shortage of staff;

- is subject to regular review by a second doctor in case of an exceptional prolongation of immobilisation beyond the six hours limit, and thereafter at reasonably frequent intervals; and that in cases of disagreement between the treating and the second doctor about the prolongation of immobilisation, the matter be automatically referred to an independent third authority for decision. The same procedure should apply if the use of mechanical restraint is repeated within 24 hours following the termination of a previous measure of restraint".

62. In its report of 7 January 2020 (CPT/Inf (2019)35), subsequent to its visit from 3 to 12 April 2019, the CPT stated, among other things:

"2. Legislative and countrywide developments in the field of psychiatry

157. As regards relevant legislative developments, the Danish Mental Health Act (hereinafter "MHA") as well as the "Executive Order No. 1338 on the use of coercion

and deprivation of liberty on psychiatric wards" have been significantly amended since the CPT's 2014 visit. The main changes relevant for the CPT's mandate concern the safeguards surrounding belt restraint and the special restraint measure of "walking restraint" (see paragraphs 179 and 170).

158. For many years, the CPT's major criticism in the psychiatric field in Denmark has been the very high frequency and long duration of instances of restraint of psychiatric patients, in particular mechanical restraint (fixation with abdominal belt and straps), which had steadily increased over many years and reached all-time peaks in 2012 and 2013. The Danish Government, acknowledging the problem, has for several years now worked towards reducing recourse to coercion in psychiatry. In 2014, it adopted an Action Plan which included, amongst other things, the overall goal of the reduction in the percentage of hospitalised patients subject to coercion on the one hand, and of the total number of instances of mechanical restraint over 48 hours on the other, each by 50% by 2020. In addition, six experimental belt-free units were to be created in psychiatric hospitals. In order to monitor the goal of the 50% reduction in coercion, the Government had further formed a "Task Force for Psychiatry".

The CPT acknowledges the considerable efforts made by the Danish authorities over the recent years to reduce recourse to coercion and in particular belt fixation by serious management involvement, the provision of additional health-care staff, increased staff training (e.g. in de-escalation techniques and communication), improved patient involvement, enhanced activities for patients and through the creation of belt-free units in psychiatric hospitals. It is particularly commendable that the total number of instances of belt restraint, the total number of prolonged belt fixations (over 24 and over 48 hours) and the percentage of patients subject to belt restraint have now been reduced significantly at the national level.

However, according to the national statistics on use of restraint, it appears that belt restraint has at least partly been replaced by other forms of coercion, mainly by "chemical restraint" (i.e. forcible administration of medication for the purpose of controlling a patient's behaviour). The Danish Health and Medicine Agency (*Sundhedsstyrelsen*) expressed its serious concerns about this "substitution effect" and reiterates its genuine commitment to achieve a long-term reduction in all means of coercion in psychiatry through a continued management focus on that goal, aimed at a long-term "cultural change in psychiatry".

The CPT further remains critical that there are still many instances of belt restraint for longer than 24 and even 48 hours. According to the national statistics, there were 408 instances per year of belt fixation for 24 to 48 hours and 439 instances per year of belt fixation for more than 48 hours in the reference period 2017/2018. It is particularly alarming that the delegation again received reports that psychiatric patients had been fixated to a bed for several months in different psychiatric hospitals pending their transfer to Sikringen. In two cases, the patients had apparently been under belt restraint for 10 and 13 months. This is completely unacceptable. Not surprisingly, one of these patients told the delegation that he required training in order to walk again properly after having been released from the belts. The CPT recommends that the Danish authorities take the necessary steps to ensure that patients are never mechanically restrained due to the lack of places at a secure psychiatric hospital.

In more general terms, the Committee strongly recommends that the Danish authorities continue their efforts to reduce recourse to means of restraint in psychiatric hospitals, and instances of prolonged belt fixation in particular. As pointed out after

the CPT's previous visits, fixating psychiatric patients for days on end cannot have any justification and may amount to ill-treatment.

Further, the utmost care should be taken to ensure that a reduction in recourse to belt fixation is not substituted by a generally increased use of other, similarly or more coercive means of restraint (notably chemical restraint)."

THE LAW

I. ARTICLE 3 OF THE CONVENTION

63. The applicant complained that he had been strapped to a restraint bed on 8 February 2013 in breach of Article 3 of the Convention, which reads as follows:

"No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

A. Admissibility

1. Submissions by the parties

64. The Government submitted that the application should be declared inadmissible as manifestly ill-founded within the meaning of Article 35 § 3 of the Convention.

65. The applicant disagreed.

2. The Court's assessment

66. The Court finds that the application is neither manifestly ill-founded nor inadmissible on any other grounds listed in Article 35 of the Convention. It must therefore be declared admissible.

B. Merits

1. Submissions by the parties

(a) The applicant

67. The applicant maintained that the application of physical restraint against him had been in breach of Article 3.

68. He reiterated that according to the preparatory notes to section 14 (*Betænkning* no. 1109/1987) (see paragraph 43 above), for a danger to be considered imminent, it had to be specific, present and demonstrable. A latent danger that might manifest itself under certain conditions or circumstances that might occur later would not suffice.

69. In the present case, the applicant submitted that neither the medical records nor the testimonies had established that there had been an imminent

danger requiring his physical restraint. Nor had it been established that other less intrusive means like personal shielding and sedative medication had been unsuccessful.

70. The applicant considered that little weight could be attached to the testimony of M.H.L, and in particular her statement before the City Court about him allegedly having said that he wanted to put a bullet through H.H.'s head. That statement was not supported by any daily records or other witnesses. Likewise, H.H.'s statement that she was sure that the applicant had been offered a sedative was not supported by any entry in his daily records.

71. Moreover, the applicant found that the opinion provided by the Medico-Legal Council had very little value, since the council could only consider the prescribing doctor's medical conclusions as to possible danger, the need for treatment and so on, as facts. The applicant therefore alleged that statements by the Medico-Legal Council constituted a medical formality, and that the council had only very rarely found that a use of restraint had not been medically indicated.

72. In the alternative, the applicant contended that the immobilisation in question, which had lasted twenty-two hours and fifty minutes, had been maintained for longer than had been strictly necessary. He reiterated that this was the longest period of immobilisation by a belt which the Court had ever dealt with. In his opinion, the domestic courts had failed to examine this issue in any particular detail, although the daily records indicated that throughout the whole period while he had been restrained he had been calm, quiet and talkative. There was no mention of violent behaviour, threats or anything like that. Moreover, despite the fact that nurses had been present during the immobilisation and had officially had the authority to discontinue the use of physical restraint in accordance with section 22(9) of Act no. 1338 of 2 December 2010, it appeared that, in the present case, in fact it was only the doctors who had had that authority.

73. The applicant also found it noteworthy that the decision to release him had been made on 9 February 2013 at 10.30 a.m., whereas he had not actually been released until 12.05 p.m.

74. Lastly, he reiterated that for more than a decade the CPT had criticised Denmark for the extensive use of mechanical restraint in prisons and psychiatric establishments, and that the United Nation's Committee Against Torture, in its latest report dated 4 February 2016 regarding Denmark, had recommended that the regulations be revised and tightened with clear and detailed guidance on the exceptional circumstances where the use of restraint might be allowed.

(b) The Government

75. The Government contended that there had been no violation of Article 3 of the Convention. Everything had been in full compliance with

the Court's case-law on the subject: the decision to physically restrain the applicant on 8 February 2013, the continuous review of the justification for maintaining the use of the restraint measure, the duration of the measure, the constant monitoring of the applicant's condition, the keeping of daily records concerning the restraint measure, and the subsequent judicial review of the lawfulness of that restraint measure.

76. The Government pointed out that the decision to immobilise the applicant had been based on a medical assessment concluding that he was dangerous to those around him, and had been taken after the use of less restrictive measures to calm him down had failed. They referred in particular to the testimony of the chief physician, H.H., who had described the applicant as being very white in the face, with fierce pent-up anger, paranoid with an inverted sense of logic, threatening, and having latent aggression. Beforehand she had left the applicant's ward several times to give him the opportunity to calm down, and had offered him sedatives, but to no avail. The applicant's behaviour on 8 February 2019 had to be seen in the light of the fact that he had made serious threats against H.H. the previous evening and had made the staff at the psychiatric hospital feel unsafe. Moreover, he had previously assaulted staff and fellow patients at psychiatric wards, and H.H. had known that from experience. The Government also referred to the testimony of M.H.L. and the opinion provided by the Medico-Legal Council.

77. During the period when the applicant had been restrained a member of staff had kept a constant watch on him, doctors had checked on him four times, and extensive records of all interactions had been kept by staff. The use of restraint had thus been maintained on the basis of thorough and continuous medical assessments, and with continuous monitoring. The doctors had made the measures less restrictive in line with the applicant's recovery, and as soon as the doctor responsible for his treatment had assessed that it was safe to release him, he had been released.

78. Lastly, the Government reiterated that all relevant aspects concerning the necessity and proportionality of the measure in question had been reviewed by the domestic courts, at two levels of jurisdiction. They had been able to hear testimony from the persons involved and obtain independent medical statements from the Medico-Legal Council. In the Government's view, those courts had therefore been in the best position to assess the course of the events and the medical assessments carried out.

2. The Court's assessment

(a) General principles

79. The Court reiterates that to fall under Article 3 of the Convention, ill-treatment must attain a minimum level of severity. The assessment of this minimum level of severity is relative; it depends on all the

circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the gender, age and state of health of the victim (see, among many other authorities, *Rooman v. Belgium* [GC], no. 18052/11, § 141, 31 January 2019).

80. Further factors include the purpose for which the treatment was inflicted, together with the intention or motivation behind it, as well as its context, such as an atmosphere of heightened tension and emotions (see *Gäfgen v. Germany* [GC], no. 22978/05, § 88, ECHR 2010).

81. The Court has recognised the special vulnerability of mentally ill persons in its case-law, and the assessment of whether the treatment or punishment concerned is incompatible with the standards of Article 3 has to take into consideration this vulnerability in particular (see, *inter alia*, *M.S. v. Croatia (no. 2)*, no. 75450/12, § 96, 19 February 2015, with further references).

82. In respect of persons deprived of their liberty, recourse to physical force which has not been made strictly necessary by their own conduct diminishes human dignity and is an infringement of the right set forth in Article 3 of the Convention (ibid., § 97, and *Bouyid v. Belgium* [GC], no. 23380/09, §§ 100-101, ECHR 2015).

83. Furthermore, the Court reiterates that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. Nevertheless, it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves, and for whom they are therefore responsible. The established principles of medicine are admittedly, in principle, decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist (*M.S. v. Croatia (no. 2)*, cited above, § 98).

84. In respect of the use of measures of physical restraint on patients in psychiatric hospitals, the developments in contemporary legal standards on seclusion and other forms of coercive and non-consensual measures against patients with psychological or intellectual disabilities in hospitals and all other places of deprivation of liberty require that such measures be employed as a matter of last resort, when their application is the only means available to prevent immediate or imminent harm to the patient or others (ibid., § 104). Furthermore, the use of such measures must be commensurate with adequate safeguards against any abuse, provide sufficient procedural protection, and be capable of demonstrating sufficient justification that the requirements of ultimate necessity and proportionality have been complied with and that all other reasonable options have failed to satisfactorily

contain the risk of harm to the patient or others. It must also be shown that the coercive measure at issue was not prolonged beyond the period which was strictly necessary for that purpose (ibid., § 105).

85. Lastly, restrained patients must be under close supervision, and every use of restraint must be properly recorded (see, among other authorities, *Bureš v. the Czech Republic*, no. 37679/08, §§ 101-103, 18 October 2012)

(b) Application of the general principles to the present case

86. The applicant complained that he had been strapped to a restraint bed on 8 February 2013. Alternatively, he complained that the restraint measure had been maintained for longer than had been strictly necessary.

The Court notes from the outset that there seems to be some uncertainty as to the exact duration of the restraint measure. It is clear that the applicant was strapped to a restraint bed with a belt and wrist and ankle straps on 8 February 2013 at 1.15 p.m. (see paragraph 19 above).

At 6.55 p.m., one foot strap was released and the applicant was released in connection with toilet visits and personal hygiene (see paragraph 24 above).

According to the daily records, on 9 February 2013 at 10.30 a.m. B.E. assessed that it was safe to release the applicant from the restraint bed. Having conferred with H.H., it was decided that the applicant should be released at 12.05 p.m. (see paragraph 26 above).

The Medico-Legal Council referred to the restraint measure having ended at 12 noon and 10.30 a.m. (see paragraph 27 above). The City Court judgment of 24 March 2017 referred to 12.05 p.m. (see paragraph 33 above), and the High Court judgment of 9 November 2017 referred to 10.30 a.m. (see paragraph 35 above).

The Court will therefore proceed on the assumption that the decision to lift the restraint measure was taken on 9 February 2013 at 10.30 a.m., and executed at 12.05 p.m. The Court notes that the parties are in agreement on that point.

To sum up, the applicant was strapped to a restraint bed with a belt and wrist and ankle straps during the first 5 hours and 40 minutes. Thereafter, during the following 17 hours and 10 minutes, one foot strap was released and the applicant was released in connection with toilet visits and personal hygiene. Altogether, the measure lasted 22 hours and 50 minutes.

87. The Court must therefore assess whether the decision to resort to the restraint measure, whether the duration of the restraint measure, and whether the manner in which it was implemented, including supervision, control and recording, complied with the requirements in Article 3 of the Convention, that is whether the use of force was strictly necessary and respected the applicant's human dignity, and did not expose him to pain and suffering in violation of the said Article.

88. The necessity and justification of the disputed restraint measure was assessed on a number of occasions by various administrative and judicial bodies.

89. Firstly, it was reviewed by the Psychiatric Patients' Complaints Board, which on 21 March 2013 found it unlawful. In the board's view, it had not been documented that the applicant had exposed himself or others to an imminent risk of harm to body or health. However, it is noteworthy that only the applicant was heard by the board. H.H., the chief physician who had made the decision at issue, fell ill, and was therefore not heard by the board; it only had a brief statement from her about the incident (see paragraph 9 above).

90. Secondly, the use of physical restraint was reviewed in connection with the applicant's complaint against H.H. lodged with the Health Authority. On the basis of a statement by the applicant and a statement by H.H. of 30 August 2014 (see paragraph 14 above), on 19 December 2014 the Health Authority found no grounds for concluding that H.H. had acted with a lack of care or conscientiousness (see paragraph 15 above).

91. Thirdly, the disputed measure was reviewed by the courts, when the applicant claimed that the State Administration should acknowledge having violated his rights under Article 3 of the Convention and pay him compensation.

92. The City Court heard evidence from the applicant, H.H. the chief physician, and the healthcare assistant M.H.L. about the disputed use of physical restraint. It also had regard to the applicant's daily records, the decisions by the Psychiatric Patients' Complaints Board and the Health Authority, the statement by H.H. of 30 August 2014, and a statement by the Medico-Legal Council of 2 June 2016. On the basis of that evidence, by a judgment of 24 March 2017, the City Court found that the conditions under section 14(2)(i) of the Mental Health Act had been fulfilled, in that it had been necessary to prevent the applicant from exposing others to an imminent risk of harm to body or health, and less intrusive measures had not been possible (see paragraph 33 above).

93. On appeal, by a judgment of 9 November 2017, on the basis of the written evidence submitted in the case, the High Court found no reason to disregard H.H.'s assessment at the time of the incident, and found that it had been necessary to strap the applicant to a restraint bed in order to avoid an imminent danger to himself or others, and that during the period while he had been restrained the staff had assessed with sufficient frequency whether the conditions for the restraint measure were still present (see paragraph 35 above).

94. Leave to appeal to the Supreme Court was refused on 15 March 2018.

95. The Court observes that European and national standards (see "Relevant domestic law" and "Relevant International and European

Material") are unanimous in declaring that physical restraints can be used only exceptionally, as a matter of last resort and when their application is the only means available to prevent immediate or imminent harm to the patient or others (see also, for example, *M.S. v. Croatia (no. 2)*, cited above, § 104, and *Bureš v. the Czech Republic*, cited above, § 95).

96. In line with these standards, the domestic courts carefully examined the case and confirmed that there had been a sufficient basis for the chief physician H.H.'s decision to strap the applicant to a restraint bed on 8 February 2013 at 1.15 p.m. on the grounds that this was necessary and proportionate to prevent him from subjecting the staff and the patients at the psychiatric hospital to an imminent risk of harm to body or health. Among other things, it was emphasised that on the previous evening the applicant had been angry and frustrated and had said "we have to do something about her", which the staff had perceived as a threat against H.H. The following morning, he had had a "lot of pent-up anger", notably when being told by H.H. that he could not go on day release while he was so angry. There had been three attempts to either enter into a dialogue with the applicant or leave him alone in order to let him calm down (see, in particular, paragraphs 14 and 19 above), but after one and a half hours he had still been extremely angry and considered to be a danger to those around him. At 1.15 p.m. on 8 February 2013 his "aggression and tension [had been] building up to such an extent that [H.H. had not] dared to [leave] him [un]restrained by a belt. [She] had felt that [everything] would go terribly wrong and escalate into violence, and that someone would get hurt". H.H. had known the applicant and his illness well, including the fact that he had been sentenced to committal to a psychiatric hospital in 2005 and had previously assaulted staff and other patients in psychiatric wards.

97. Before the City Court H.H. stated that she was "entirely sure that the applicant had been offered a sedative before being physically restrained with the belt" (see paragraph 30 above). Before the Court the applicant contested that he had been offered a sedative by H.H. He emphasised that this was not supported by any entry in his daily records. Before the Court the applicant also maintained that "personal shielding" (section 18 d of the Mental Health Act) could have been used as a less intrusive measure. The Court cannot see that these issues were specifically relied on by the applicant before the domestic courts, which may explain why they were not separately addressed by the City Court and the High Court. It is not for the Court to speculate as to whether a sedative was offered or not, or whether, having regard to the information about the applicant's state and behaviour, a sedative or "personal shielding" could and should have been resorted to as an alternative to the measure applied. It observes, though, that the City Court in general stated "that it has been documented that measures less intrusive than physical restraint were not possible, see the principle of the least intrusive measure in section 4 of the Act" (see paragraph 33 above).

98. The Court is thus satisfied that it was demonstrated that the immobilisation of the applicant was employed as a matter of last resort, and was the only means available to prevent immediate or imminent harm to others (see paragraph 84 above).

99. The applicant submitted that for more than a decade the CPT had criticised Denmark for the extensive use of physical restraint in prisons and psychiatric institutions, and that the United Nation's Committee Against Torture, in its report of 4 February 2016, had expressed concern "at the frequent recourse to coercive measures, often accompanied by immobilisation of patients, in psychiatric institutions, in spite of the fact that the Psychiatric Act stipulates that they should be used as a last resort" (see paragraphs 54 and 61 above in particular).

100. The Court is always attentive to positions held by other international institutions such as the CPT and the United Nation's Committee Against Torture. It will be recalled though that the Court performs a conceptually different role from the one assigned to the CPT, whose responsibility does not entail pronouncing on whether a certain situation amounts to inhuman or degrading treatment or punishment within the meaning of Article 3 (see, for example, *Muršić v. Croatia* [GC], no. 7334/13, §113, 20 October 2016). Likewise, in the report of 4 February 2016 regarding Denmark (see paragraph 54 above), the United Nation's Committee Against Torture expressed its general concern rather than its concern in a specific case or a concrete hospital.

101. Finally, in cases arising from individual petitions, the Court's task is not to review the relevant legislation or an impugned practice in the abstract. Instead, it must confine itself, as far as possible, without losing sight of the general context, to examining the issues raised by the case before it (see, for example, *Donohoe v. Ireland*, no. 19165/08, § 73, 12 December 2013; *Julin v. Estonia*, cited above, § 126; *Nejdet Şahin and Perihan Şahin v. Turkey* [GC], no. 13279/05, §§ 69-70, 20 October 2011; *Taxquet v. Belgium* [GC], no. 926/05, § 83 *in fine*, ECHR 2010; and *Religionsgemeinschaft der Zeugen Jehovas and Others v. Austria*, no. 40825/98, § 90, 31 July 2008).

102. The Court will now proceed to examine the continuation and duration of the physical restraint measure. The Court recalls in this context that it is not sufficient that the decision to resort to the restraint measure was "strictly necessary" to prevent an immediate and imminent risk of harm to other persons. In addition, it is also a requirement that the restraint measure is not prolonged beyond the period which was "strictly necessary" (see paragraph 84 above), and that it is for the State to demonstrate convincingly that this condition was met.

103. The applicant pointed out that he had been strapped to the restraint bed for almost twenty-three hours, which was the longest period of immobilisation by a belt which the Court had ever dealt with.

104. The Court therefore finds it appropriate to compare the present case with some previous cases in which it found that strapping a person to a restraint bed had been in violation of Article 3 of the Convention.

At the outset, the Court reiterates that the applicant in the present case was suffering from paranoid schizophrenia and had been sentenced to committal to a psychiatric hospital owing to five incidents of violence against civil servants acting in their official functions. Furthermore, as concluded above, the decision by the chief physician at the hospital to strap the applicant to a restraint bed on 8 February 2013 was found to be necessary in order to prevent him from exposing others to violence.

The case at hand should thus be distinguished from cases on the physical restraint of prisoners, where the Court has stated that strapping a person to a restraint bed – in the absence of medical reasons – is a measure which should rarely be applied for more than a few hours, see, for example, *Julin v. Estonia* (nos. 16563/08 and 3 others, § 127, 29 May 2012). In that case, the applicant had already been locked in a single-occupancy disciplinary cell before he was placed in a restraint bed for nine hours.

It may also be distinguished from *Tali v. Estonia* (no. 66393/10, §§ 81-82, 13 February 2014), where a measure whereby the applicant was strapped to a restraint bed for three hours and forty minutes, when implemented along with other measures such as his placement in a single-occupancy disciplinary cell and the use of physical force, handcuffs, pepper spray and telescopic batons, amounted to inhuman and degrading treatment.

In both cases, the Court emphasised that restraint should never be used as a means of punishment, but rather to avoid self-injury or serious danger to other persons or prison security.

The case at hand can also be distinguished from *M.S. v Croatia* (cited above), where the Court found that physical restraint for fifteen hours was the principal element that appeared worrying (ibid., §§ 99-100). However, it should be reiterated that, unlike the applicant in the present case, Mrs M.S. was not confined to a psychiatric hospital owing to a criminal conviction for violence. She went to see her family doctor, who sent her to the emergency health service, which prescribed hospitalisation. She was immediately, against her will, admitted to a psychiatric clinic, where, on the same day, she was strapped to a restraint bed. Moreover, her alleged aggression was only indicated in her record after the measure had already been used, and the records did not suggest that she had attempted to attack anyone. In addition, she had physical health problems and complained of pain in her back several times during the period while she was restrained.

Lastly, the present case can be distinguished from *Bureš v. the Czech Republic* (cited above), where the applicant was a fragile man of slight build who was suffering from a mental illness. He was taken to a sobering-up centre in a state of intoxication and was immediately strapped to a restraint

bed for several hours due to alleged "restlessness". His subsequent restraint was justified by his allegedly aggressive behaviour towards a male nurse, but there were no reports of this to the police, and there were no details about the nature of the attack anywhere in the case file. In addition, due to the restraint, Mr Bureš suffered severe bilateral paresis of the elbow nerves.

105. It follows that the present case is distinguishable from the cases so far examined by the Court, and that it cannot be concluded that the duration of almost twenty-three hours for the applicant to be strapped to the restraint bed is, per se, sufficient to find a violation of Article 3. It will depend on whether the continuation and duration of the measure of physical restraint in respect of the applicant was the only means available to prevent immediate or imminent harm to himself or others (see, *M.S. v Croatia*, cited above, § 104).

106. The domestic courts confirmed that the continuation and duration of the physical restraint measure in respect of the applicant had been necessary and proportionate to prevent him from subjecting others to an imminent risk of harm to body or health. It was undisputed that a social and healthcare assistant had been present with the applicant throughout the period while he had been restrained, and that the observations of those assistants had regularly been entered in his daily records. Moreover, doctors had been to see the applicant four times.

107. From the applicant's daily records, it was apparent that H.H. had been to see the applicant at 2.45 p.m. and he had still had a great deal of pent-up anger. He had appeared to have latent aggression. At 6.55 p.m. Doctor B.E. had found that the applicant appeared more "quiet" and talkative, and had therefore decided to release one ankle strap and allow the applicant to be released in connection with toilet visits and personal hygiene. Thus, after less than six hours the measure was relaxed. Despite that progress, at 10.46 p.m. B.E. had decided that the applicant was still potentially dangerous to other people because of his "instinctive anger". The following day, on 9 February 2013 at 6 a.m. M.O., a carer, had written that the applicant had slept throughout the night. At 10.30 a.m. B.E. had decided that it was safe to release the applicant from the restraint bed, and following a discussion with H.H. the applicant had been released at 12.05 p.m.

108. On the basis of the information before them, including the statement from the Medico-Legal Council, the domestic courts were confident that during the period when the applicant had been physically restrained, medical evaluations had been carried out with sufficient frequency to assess whether the conditions for the restraint measure were still present.

109. The Court reiterates that the domestic courts had the benefit of direct contact with all the persons concerned, and that the assessment of whether the use of restraint in respect of the applicant was necessary was first and foremost a medical assessment (see *M.S. v Croatia*, cited above,

§ 98, and, *mutatis mutandis*, *Herczegfalvy v. Austria,* no. 10533/83, § 82, 24 September 1992).

110. Nevertheless, in the Court's view, the domestic courts were silent on several issues, which were crucial for the assessment of whether the continuation of the restraint, and its duration for almost twenty-three hours, was "strictly necessary" to prevent immediate or imminent harm to others.

111. Firstly, the Court notes that although at 6.55 p.m. Doctor B.E. found that the applicant appeared more "quiet" and talkative, and therefore decided to release one ankle strap and allow the applicant to be released in connection with toilet visits and personal hygiene, at 10.46 p.m., that is approximately four hours later, he nevertheless maintained the immobilisation, because he found that the applicant was still "potentially" dangerous to other people because of his instinctive anger. The Court recalls in this respect that a "potential" danger does not suffice to establish that a danger is immediate or imminent. That was also specified in the preparatory notes to section 14 of the Mental Health Act (see paragraph 43 above), which stated that "for a danger to be considered imminent, it must be specific, present and demonstrable. However, a latent danger that may manifest itself under certain conditions or circumstances that may occur later will not suffice."

112. Secondly, between 8 February 2013 at 10.46 p.m. and the following day, 9 February 2013, at 10.30 a.m., that is a period of almost twelve hours, the applicant was not attended to by a doctor. It is not disputed between the parties, as written by M.O. in the applicant's daily records at 6 a.m., "that the evening had been quiet and the applicant had slept throughout the night", or that there was always a social and healthcare assistant present with the applicant, but it remains the fact that in the end it was a doctor who took the decision to release him and that there was no danger assessment carried out by a doctor for almost twelve hours.

113. Thirdly, although B.E. had decided that it was safe to release the applicant on 9 February 2013 at 10.30 a.m., he was actually not released until 12.05 p.m., that is until H.H. had been consulted. Accordingly, the physical restraint was prolonged by one hour and thirty-five minutes without any explanation for this delay.

114. In these specific circumstances, in particular having regard to the available information about the applicant's state during the evening and night of 8 February 2013, and the delay in releasing him *de facto* on 9 February 2013, and the domestic courts' failure to specifically address these issues, the Court cannot conclude that it has been sufficiently proven that the continuation and the duration of the restraint measure for almost twenty-three hours was strictly necessary and respected the applicant's human dignity, and did not expose him to pain and suffering in violation of Article 3 of the Convention (see *M.S. v. Croatia*, cited above, § 105).

115. It follows that there has been a violation of Article 3 of the Convention.

II. APPLICATION OF ARTICLE 41 OF THE CONVENTION

116. Article 41 of the Convention provides:

> "If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party."

A. Damage

117. The applicant claimed 40,000 Euros (EUR) in compensation for non-pecuniary damage relating to the alleged violation of Article 3 of the Convention.

118. The Government submitted that the claim was excessive.

119. The Court considers it undeniable that the applicant sustained non-pecuniary damage on account of the violation of Article 3 of the Convention. Making its assessment on an equitable basis as required by Article 41 of the Convention, it awards EUR 10,000 under this head.

B. Costs and expenses in the domestic proceedings

120. The applicant claimed reimbursement of the costs and expenses incurred in the domestic proceedings, amounting to 146,500 Danish Kroner (DKK) (equal to approximately EUR 19,700), which had been paid by his insurance company.

121. The Government emphasised that the applicant had not paid the said costs, nor was he liable to pay them.

122. The Court reiterates that only legal costs and expenses found to have been actually and necessarily incurred and which are reasonable as to quantum are recoverable under Article 41 of the Convention (see, for example, *Dudgeon v. the United Kingdom* (Article 50), 24 February 1983, § 22, Series A no. 59). The Court further notes that the costs of the domestic proceedings may be awarded if they are incurred by an applicant in order to try to prevent the violation found by the Court or to obtain redress therefor (see, among other authorities, *Lopata v. Russia*, no. 72250/01, § 168, 13 July 2010).

123. In the present case, it is not in dispute between the parties that the costs claimed were indeed paid by the applicant's insurance company. Accordingly, the Court makes no award in respect of the costs incurred in the domestic proceedings.

C. Costs and expenses before the Court

124. The applicant claimed the costs and expenses incurred in the Convention proceedings in the amount of DKK 131,981 (equal to approximately EUR 17,700), corresponding to legal fees for a total of 57 hours of work, carried out by his representative, and to translation costs in the amount of DKK 6,937 inclusive of VAT, (equal to approximately EUR 930).

125. The Government found the amount excessive and noted that the applicant had been granted legal aid under the Danish Legal Aid Act (*Lov 1999-12-20 nr. 940 om retshjælp til indgivelse og førelse af klagesager for internationale klageorganer i henhold til menneskerettighedskonventioner*) and that the Department of Civil Affairs had notified the applicant of a provisional grant of legal aid up to DKK 40,000 (equal to approximately EUR 5,400). In the Government's view that sum was sufficient to cover the legal costs related to the case before the Court.

126. In the present case, the applicant has provisionally been granted DKK 40,000 under the Danish Legal Aid Act. However, it is uncertain whether the applicant will subsequently be granted additional legal aid by the Ministry of Justice and how a dispute between the parties about the applicant's outstanding claim for legal aid is to be decided. Therefore, the Court finds it necessary to assess and decide the applicant's claim for costs and expenses.

127. According to the Court's case-law, an applicant is entitled to the reimbursement of costs and expenses only in so far as it has been shown that these have been actually and necessarily incurred and were reasonable as to quantum. In the present case, regard being had to the documents in its possession, the above criteria, and awards made in comparable cases against Denmark (see, among others, *Tim Henrik Bruun Hansen v. Denmark*, no. 51072/15, § 92, 9 July 2019 and *Osman v. Denmark*, no. 38058/09, § 88, 14 June 2011), and the fact that the applicant has already been paid DKK 40,000 under the Danish Legal Aid Act, the Court considers it reasonable to award the sum of EUR 4,000 covering the costs for the proceedings before the Court, including the legal fee and translation costs.

D. Default interest

128. The Court considers it appropriate that the default interest rate should be based on the marginal lending rate of the European Central Bank, to which should be added three percentage points.

FOR THESE REASONS, THE COURT UNANIMOUSLY

1. *Declares* the application admissible;

2. *Holds* that there has been a violation of Article 3 of the Convention;

3. *Holds*
   (a) that the respondent State is to pay the applicant, within three months from the date on which the judgment becomes final in accordance with Article 44 § 2 of the Convention, the following amounts:
      (i) EUR 10,000 (ten thousand euros) in respect of non-pecuniary damage;
      (ii) EUR 4,000 (four thousand euros), in respect of costs and expenses;
      (iii) any tax that may be chargeable to the applicant on the above amounts;
   (b) that these sums are to be converted into the national currency of the respondent State at the rate applicable at the date of settlement;
   (c) that from the expiry of the above-mentioned three months until settlement simple interest shall be payable on the above amounts at a rate equal to the marginal lending rate of the European Central Bank during the default period plus three percentage points;

4. *Dismisses* the remainder of the applicant's claim for just satisfaction.

Done in English, and notified in writing on 15 September 2020, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Stanley Naismith Registrar	Marko Bošnjak President