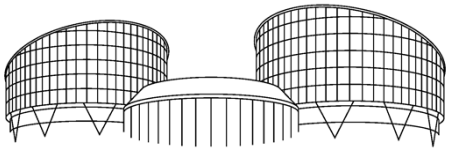

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FOURTH SECTION

CASE OF MAKKI v. DENMARK

(Application no. 10297/23)

JUDGMENT

Art 3 (substantive) • Inhuman and degrading treatment • Prolongation of the restraint of the applicant, suffering from paranoid schizophrenia, to his bed for 11 days and 11 hours in a psychiatric hospital, after assaulting a nurse, pending his transfer to a high security facility • Delay did not sit well with the relevant European and national standards nor was it in accord with the Danish legislators' aim to reduce the use of compulsory restraint in general • Not sufficiently proven that the prolongation of the restraint measure, given its duration, was strictly necessary, respected the applicant's human dignity and did not expose him to pain and suffering

Prepared by the Registry. Does not bind the Court.

STRASBOURG

31 March 2026

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 Makki v. Denmark,

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

Lado Chanturia*, President*,
Jolien Schukking,
Faris Vehabović,
Ana Maria Guerra Martins,
Anne Louise Bormann,
Sebastian Răduleţu,
András Jakab*, judges*,
and Hasan Bakırcı, *Section Registrar,*

Having regard to:

the application (no. 10297/23) 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 Abdeelhadi Abbas Makki ("the applicant"), on 21 February 2023;

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

the observations submitted by the respondent Government and the observations in reply submitted by the applicant;

the comments submitted by the non-governmental organisations Dignity – Danish Institute against Torture, and the Danish Institute for Human Rights, which were granted leave to intervene by the President as third-party interveners in the proceedings (Article 36 § 2 of the Convention and Rule 44 § 3 of the Rules of Court);

Having deliberated in private on 10 February and 10 March 2026,

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

INTRODUCTION

1. The applicant suffers from paranoid schizophrenia. After being admitted to a psychiatric hospital he assaulted a nurse there and was strapped to a restraint bed from 1.30 p.m. on 3 June 2016 to 8.18 p.m. on 16 June 2016. He complains that that measure, from 9.30 a.m. on 5 June 2016 onwards, was in breach of Article 3 of the Convention.

THE FACTS

2. The applicant was born in 1995 and lives in Slagelse. He was represented by Mr Tobias Stadarfeld Jensen, a lawyer practising in Aarhus.

3. The Government were represented by their Agent, Ms Vibeke Pasternak Jørgensen, of the Ministry of Foreign Affairs, and their co-Agent, Ms Nina Holst-Christensen, of the Ministry of Justice.

4. The facts of the case may be summarised as follows.

5. The applicant suffers from schizophrenia and a mild intellectual disability. He was admitted to a psychiatric hospital several times (voluntarily and involuntarily) in 2015 and 2016, including on 10 May 2016 owing to an incident in which he used violence against a family member.

6. After being discharged, he was involuntarily readmitted to a psychiatric hospital on 3 June 2016. There he assaulted a nurse by putting an arm around the nurse's neck and stabbing him in the back of the head and the upper back nine times with a fork.

7. Consequently, at 1.30 p.m. the applicant was strapped to a restraint bed with a belt and foot and wrist straps. He remained strapped to the bed until 8.18 p.m. on 16 June 2016, when the measure was formally lifted in order to transfer the applicant first to the Department of Forensic Psychiatry at Middelfart Hospital and thereafter, on 28 February 2019 to the High-Security Psychiatric Unit (*Sikringsafdelingen*).

8. While restrained, however, one or other of the straps were sometimes removed for certain periods. Moreover, once a day for about thirty minutes the applicant was released, with the assistance of the police, to shower, go outdoors and smoke. He was under the constant observation of medical staff and was attended to several times per day by psychiatrists, who reviewed the justification for his being physically restrained in the light of the statutory requirements set out in the Mental Health Act.

9. On 9 June 2016 the chief psychiatrist responsible for the applicant's care applied for a so-called "dangerousness decree" (*farligheds-dekret*) (see paragraph 24 below). It was issued on 23 March 2018 by the Ministry of Justice and approved by a court on 21 August 2018. Under a dangerousness decree, extraordinarily dangerous persons who are mentally ill and who constantly pose a serious and imminent danger to the life or body of others, where less intrusive measures are insufficient, must be placed at the High-Security Psychiatric Unit, the only institution of its kind in Denmark. The applicant was placed there on 28 February 2019.

10. On 5 March 2019, the applicant complained to the Psychiatric Patients' Complaints Board (*Det Psykiatriske Patientnævn*) about his having been physically restrained from 3 June to 16 June 2016. In a decision of 20 May 2019, the Board found in his favour in part. It found that the use of physical restraints from 1.30 p.m. on 3 June until 9.30 a.m. on 5 June 2016 had been lawful whereas the measure's continuation from 9.30 a.m. on 5 June to 8.18 p.m. on 16 June 2016 had been unlawful. In respect of the latter period, the Board assessed that the imposition of restraints had lasted for longer than necessary in that the authorities had failed to substantiate that there had been a specific, present and demonstrable risk that the applicant had been a danger

to others. The Board also expressed concern regarding the fact that the mandatory medical assessment after 48 hours, which occurred on 5 June 2016, had not been performed by an external psychiatrist but by B.J., the chief psychiatrist responsible for the applicant's care, and that on several occasions the time span from one medical assessment to the next had been around twelve hours or more, which was not in accordance with section 21 of the Mental Health Act.

11. By virtue of section 37 of the Mental Health Act (see paragraph 42 below) the case was brought before the District Court (*Retten i Næstved*) against the Region of Southern Denmark. The applicant claimed damages for a violation of Article 3 of the Convention due to his restraint from 9.30 a.m. on 5 June 2016 to 8.18 p.m. on 16 June 2016.

12. The applicant's daily medical records were submitted to the District Court. In so far as relevant, they included the following quotations or events.

13. At 3.16 p.m. on 3 June 2016 the applicant was described by a nurse as being "awake and offer[ing] relevant answers when questioned". He asked if the nurse he had stabbed was all right and he apologised multiple times for his behaviour.

14. At 9.48 p.m. on 3 June 2016 a nurse wrote, among other things: "... As agreed with Chief Psychiatrist B.J., [the applicant] must remain restrained with a belt over the weekend here at P1 Ward or, if [he] is deemed sufficiently calm tomorrow to [be released from the restraints], he must be referred to Odense University Hospital (OUH) while [still being] restrained with a belt, which can only be removed after his arrival [there]. OUH refuses to accept [the applicant] if he still needs to be restrained with a belt."

15. At 10.34 p.m. on 3 June 2016 a nurse wrote, *inter alia*:

> "... [the applicant] remains restrained with a belt until tomorrow... All through the evening the straps are changed, so that [the applicant] has a foot or a hand free from the stap at all times ... that is by agreement with Chief Psychiatrist B.J., and K., the first doctor on call. [The applicant] cooperated ... [with the straps being changed] ... [but he] becomes slightly irritated when the conversation touches on his brother. Otherwise, friendly and cooperative ..."

16. At 12 noon on 4 June 2016 a nurse wrote:

> "... [one of the] wrist strap[s] changed at 8.10 a.m. (the left one is the one released now). When I try to tighten the right wrist strap, [the applicant] lashes out at me. Severely reprimanded and cooperates afterwards. ... H[e h]as been assessed by J.B., the second doctor on call. Please refer to her note. [The applicant] to stay restrained using three straps until ... an assessment tomorrow."

17. At 9.30 a.m. on 5 June 2016 B.J. wrote:

> "[When there is contact with] the patient, [he] shouts that he promises not to do anything to anybody; [he] believes that the reason for his attack on a member of staff was self-defence. Promises me to stay calm. However, the patient becomes irascible again as soon as I leave the room; it is difficult to control his behaviour [and] the patient is deemed to still pose a risk to others ... therefore mechanical restraint with two foot straps and one wrist strap is [being] continued. ...

> The patient prefers to talk about himself as being blameless for the assault of the staff member; he still believes that it was self-defence. He also asserts that he is now quiet and calm and that he will not do anything.
>
> I point out to the patient that he was also quiet and calm on the day when he arrived from Bispebjerg Hospital and that the assault occurred without any warning, and that for that reason we are concerned about his violent behaviour."

18. At 1.22 p.m. on 5 June 2016 B.J., who carried out the 48 hours mandatory medical assessment – which, as found by the Board (see paragraph 10 above), should have been carried out by an external psychiatrist – wrote:

> "[He i]s still dissatisfied about being restrained with a belt, has just been angry and has made verbal threats. Continues to believe that he is at no fault in the incident. Promises never again to do anything to anybody, but as soon as I leave the room the patient starts testing limits and becomes irascible again ...
>
> Awake, alert and orientated – apparently friendly and smiling. But only towards me, irascible towards other staff members. Self-possessed and [speaking] pertinently, pronounced externalizing behaviour. Apparently, no productive symptoms, but [was] observed mumbling to himself [and] having paranoid delusions that there is something in the cookies.
>
> The patient is deemed to still pose a risk to others and therefore mechanical restraint with a belt, a foot strap and a wrist strap, which are alternated every hour, is continued."

19. At 10.30 a.m. on 6 June 2016 B.J. wrote, *inter alia*:

> "The patient lies calmly in his bed [and] would like to be relieved of the restraints, however, so far it has been difficult to make any agreement with him in this respect. The patient is told that we are struggling very hard to find a solution for him to be released [from the restraints] but that I am unable to release him now because he has been so dangerous."

20. At 1.00 p.m. on 7 June 2016 the chief psychiatrist of another hospital, C.BP., whose role it was to provide an external, second opinion of the mechanical restraint, wrote:

> "Conclusion and plan: ... 'It is therefore my assessment that the patient must still be deemed to be seriously mentally ill and dangerous to those around him, and in the current situation I see no other option but to keep the patient mechanically restrained while allowing him some degree of freedom in the presence of police officers.'"

21. Starting on 7 June 2016 the police came once a day – at the request of B.J. – for around thirty minutes so that the applicant could be released in order to shower, smoke and get some fresh air.

22. At 8.29 p.m. on 7 June 2016 the applicant threw a cup of coffee at the staff member tasked with constantly monitoring him and threatened to kill all the staff members with a knife.

23. At 4.15 p.m. on 8 June 2016 the applicant was still considered seriously mentally ill and deemed to pose an immediate risk of harm to others, and he therefore remained mechanically restrained with a belt, one wrist strap and one foot strap.

24. On 9 June 2016 B.J. applied for a so-called "dangerousness decree" in order to have the applicant transferred to the High-Security Psychiatric Unit where extraordinarily dangerous persons are treated, in accordance with Chapter 11 of the Mental Health Act.

25. At 12.30 p.m. on 9 June 2016, C.BP., in the course of his weekly medical assessment, wrote:

> "Given the [circumstances], because we are waiting for the Ministry of Justice's decision to issue a 'dangerousness decree' and since [the applicant] still is deemed to be dangerous to other people, I cannot see that anything can be done other than to have [the applicant] restrained. [The applicant] is released to the extent it is feasible, and when the police are present."

26. On 10 June 2016 the wrist straps were removed. The applicant was still restrained by one foot strap. After members of the applicant's family visited him, he became extremely threatening towards the staff member tasked with constantly monitoring him, whom the applicant threatened to stab.

27. On 12 June 2016 the applicant flung his bedside table, chair and mug towards the corridor, with the aim of hitting staff member monitoring him. The applicant also threatened to kill her. The police were called, and a wrist strap was applied. His foot and wrist straps were subsequently alternated regularly.

28. From 14 June 2016 wrist straps were no longer used. The applicant continued to be mechanically restrained with a belt and a foot strap.

29. By a judgment of 3 September 2019, the District Court found against the applicant for the following reasons:

> "The European Court of Human Rights has found several times that the mechanical restraint of psychiatric patients is contrary to Article 3 of the European Convention on Human Rights, which says that no one shall be subjected to torture, nor to inhuman or degrading treatment or punishment.
>
> The purpose of the 2015 amendment to the Mental Health Act and thus the tightening of the rules on the use of mechanical restraint in section 14 of the Act was to reduce the use of mechanical restraint. Accordingly, considerations for the protection of patients prevail when determining whether it is possible in any case to apply mechanical restraint within the scope of the Convention.
>
> The European Court of Human Rights has also said that mechanical restraint may be used only as a last resort to avoid a risk of injury to a patient or others, that mechanical restraint may not be applied for longer than strictly necessary, and that mechanical restraint may not in any circumstances be justified by a lack of staff.
>
> It follows from section 14(2)(i) and section 14(3) of the Mental Health Act that the application of mechanical restraint requires that there is an imminent risk to the body or health of a patient or others and that the maximum period of mechanical restraint is a few hours unless [a longer period is] justified having regard to the life, health or safety of the patient or others.
>
> According to the case file, [the applicant] was mechanically restrained at 1.30 p.m. on 3 June 2016 after having, among other things, assaulted a staff member with a fork,

with which he had stabbed the back of the head and upper back of that staff member several times. [The applicant] was mechanically restrained with the assistance of police officers. Those involved agreed that he was mechanically restrained in accordance with section 14(2)(i) of the Mental Health Act.

The medical records describe [the applicant] during the subsequent period and until his transfer on 16 June 2016 to the Department of Forensic Psychiatry ... as constantly displaying swift changes in his mood from calm to threatening, as lacking awareness of his disease or having no realistic awareness of his own acts, whether immediately prior to or during the period of the mechanical restraint, and as displaying externalising behaviour against staff. Moreover, he also sometimes resisted [taking] medication.

Throughout the entire period, [the applicant] was deemed to be mentally ill and a risk to others, which was the reason for continuing the mechanical restraint. The assessment was made by B.J., the treating chief psychiatrist, who had prior knowledge of [the applicant] and thus of his behaviour patterns and the validity of his utterances stating his intention to be cooperative. The assessment was approved by several other external psychiatric specialists who assessed [the applicant].

B.J., the chief psychiatrist, has stated that [the applicant] turned aggressive when his behaviour was controlled and when things did not go his way, that he lacked impulse control and had a low threshold for losing his temper, and that it was not possible to administer medication to alleviate the severity of the situation.

Referring to that statement, the court finds that regard for the life or security of others justified the continuation of the mechanical restraint of [the applicant] from 9.30 a.m. on 5 June 2019 until 8.18 p.m. on 16 June 2019; thus, the restraining measure was in accordance with section 14(3) of the Mental Health Act.

The Psychiatric Patients' Complaints Board expressed concern about the fact that the mandatory medical assessment after 48 hours on 5 June 2016 was performed by B.J., the treating chief psychiatrist, and that on more than one occasion the time span from one medical assessment to the next was around 12 hours or more, which was not in accordance with the rules in section 21 of the Mental Health Act. The court finds that the circumstances that the mandatory medical assessments under section 21(4) of the Mental Health Act were not performed at regular intervals around the clock and that the mandatory medical assessment after 48 hours required by section 21(6) of the same Act was performed by the treating chief psychiatrist do not amount to such serious disregard for [the applicant's] legal rights that they could independently justify the finding that the mechanical restraint should be deemed unlawful.

In making this finding, the court has taken into account that ongoing medical observation [by members of staff] was performed around the clock, but that the medical assessments were not performed at regular intervals as the staff considered that it was better to allow [the applicant] to rest than to perform the medical assessments at the usual intervals and that both the mandatory 24-hour medical assessment and the ... medical assessment on the fourth day were performed by external psychiatrists, both of whom assessed that the conditions for mechanical restraint had been met.

Based on the above, the court deems that the mechanical restraint of [the applicant] was lawful and dismisses the claim against the Region of Southern Denmark for ... damages. The court finds that the circumstances that the mandatory medical assessments under section 21(4) of the Mental Health Act were not performed at regular intervals around the clock and that the mandatory medical assessment after 48 hours required by section 21(6) of the same Act was performed by the treating chief psychiatrist do not amount to such serious disregard for [the applicant's] legal rights

that they could independently justify the finding that the mechanical restraint should be deemed unlawful.

Based on the above, the [c]ourt deems that the mechanical restraint of the complainant was lawful and dismisses the claim against the Region of Southern Denmark for payment of damages."

30. The applicant appealed against that decision to the Eastern High Court (*Østre Landsret*), which by a judgment of 6 October 2020 found in his favour for the following reasons:

"Introductory observations

... [the applicant] has not disputed the lawfulness of the mechanical restraint from 1.30 p.m. on 3 June 2016 to 9.30 a.m. on 5 June 2016.

...

The case thus concerns whether the mechanical restraint of [the applicant] from 9.30 a.m. on 5 June 2016 to 8.18 p.m. on 16 June 2016 was lawful and, if not, whether he is entitled to damages and, if so, the amount of such damages.

Lawfulness of the mechanical restraint

It follows from section 14(2)(i) of the Mental Health Act that mechanical restraint may normally be used only briefly, that is, for few hours, see subsection (3), and only to the extent necessary to prevent a patient from subjecting himself/herself or others to an imminent risk of harm to body or health.

It appears from the preparatory notes to that provision that the concept of 'imminent risk' must be construed to mean a 'specific, present and demonstrable risk'.

According to section 14(3) of the Mental Health Act, mechanical restraint can be used for a period of more than a few hours if justified having regard to the life, health or safety of the patient or others.

According to the preparatory notes to the provision, it is a requirement that there must be 'substantial reasons' in the form of an 'imminent and substantial risk' to the person himself/herself or others, whereas a distant or uncertain risk that such risk may manifest itself does not suffice.

It also appears from the preparatory notes to the 2015 Act amending section 14(2) and (3) of the Mental Health Act and other provisions that, based on, *inter alia*, the repeated concern expressed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), the amendment was intended to reduce the use of mechanical restraint by 50%.

The relevant provisions must also be viewed in connection with the general provisions on proportionality set out in section 4 of the Act and the rules in section 21(4) to (6) of the Act on continuous medical supervision and [regular] assessments by an external chief psychiatrist in connection with belt restraint, which, according to the preparatory notes to those provisions, constitute due process protection of the rights of mechanically restrained patients.

In the case at hand, [the applicant] assaulted a nurse in a very serious and dangerous manner on 3 June 2016 at around 1.30 p.m. without prior warning, which was the reason why he was mechanically restrained. During the period of mechanical restraint, he displayed labile behaviour, irascibility, irritability, and a refusal to accept his responsibility for the assault, etc.

During the first medical assessment at 7.30 p.m. on 3 June 2016 it was decided to release one strap so that [the applicant] had one limb free from that point on. At the same time, staff began to alternate [the limbs on which] the three remaining straps [were placed] approximately every thirty minutes.

In connection with one of those alternations (at 8.10 a.m. the next morning), [the applicant] lashed out at a nurse, but became cooperative ... after he had been 'severely reprimanded'.

It is not apparent from the medical records whether, between then and the medical assessment at 9.30 a.m. on 5 June 2016 [the applicant] lashed out at nursing staff or doctors in connection with the regular alternation of straps or the medical assessments.

In connection with the medical assessment at 9.30 a.m. on 5 June 2016, [the applicant] was described as shouting, being irascible and exhibiting behaviour that was difficult to control. No information has been provided as to whether [the applicant] made verbal threats of violence during with the medical assessment in question or on previous occasions during the period of mechanical restraint. It was decided in connection with the medical assessment that [the applicant] should continue to be mechanically restrained and that the restraining devices should continue to be a belt and three straps.

According to the case notes entered on 4 June 2016 at 1.30 p.m., there seems to be doubt as to whether the relevant medical assessment was performed by a doctor not working at the P1 Ward and thus whether the medical assessment was in fact made by an external chief psychiatrist as required by section 21(5) of the Mental Health Act.

Against this background and since no attempt was otherwise made, for example, to release yet another strap and then assess [the applicant's] behaviour in that situation, the High Court finds – despite the sudden and highly aggravated assault on 3 June 2016 and [the applicant's] serious mental illness, labile behaviour, etc. – that it has not been justified that the mechanical restraint had to continue after 9.30 a.m. on 5 June 2016 out of regard for the life, health or safety of the patient or others.

The mechanical restraint of [the applicant] after 9.30 a.m. on 5 June 2016 was therefore not lawful [nor in accordance with] section 14(2) and (3) of the Mental Health Act.

Damages

[The applicant] has accordingly been mechanically restrained without justification for a continuous period of almost eleven and a half days.

Considering the resulting stressful situation, the High Court finds that Article 3 of the European Convention of Human Rights has been violated and that [the applicant] is therefore entitled to damages for such violation ...

In determining the amount of the damages, it must be taken into account, on the one hand, that [the applicant] was mechanically restrained on the bed without justification for almost eleven and a half days, which must be considered a serious interference.

On the other hand, it must also be taken into account that the continuous medical assessment of the justification of the mechanical restraint must be deemed to have been difficult owing to [the applicant's] serious mental illness and the way that it manifested itself, including his labile and unforeseeable behaviour leading to an unprovoked and highly aggravated assault on a nurse two days earlier.

Based on an overall assessment, 50,000 Danish kroner is considered to be a suitable amount of damages ..."

31. The applicant was granted leave to bring an appeal seeking a higher amount of damages in the Supreme Court (*Højesteret*).

32. The Region of Southern Denmark made an application to the Supreme Court seeking that the Medico-Legal Council (*Retslægerådet)* be consulted. The application was granted, and on 25 April 2022 the Medico-Legal Council issued the following opinion:

> "In connection with our reply to the request, the Medico-Legal Council would like to refer to a number of previous opinions concerning [the applicant], most recently the opinion of 5 November 2021, and would now say, based on the case-files received, including the medical report of 5 April 2019 prepared by B.J., chief psychiatrist of Psychiatric Ward P1 of the Mental Health Service of the Region of Southern Denmark at Svendborg Hospital, that [the applicant] is now a 26-year-old male who has been ill-adjusted since childhood and who has suffered from a severe mental disorder since early adolescence (diagnosed as severe schizophrenia in 2015), has faced severe cognitive challenges and has abused various intoxicants. Prior to the relevant period of mechanical restraint, he was involuntarily admitted to hospital because of the danger he posed to those around him. He grew up in Copenhagen but moved to the island of Funen in 2015 at the age of 20 at the initiative of his family, who wanted to distance him from gang-related criminal environments. He mostly lived with family members as none of the socio-psychiatric residential homes offered to him were able to cater to his needs. According to medical records, [the applicant's] family requested that he be admitted to the Psychiatric Unit on 10 May 2016 after a violent incident against a family member. After he had beaten a fellow patient without any warning, [the applicant] was restrained with a belt on 11 May 2016 with the assistance of the police, the restraint measure being terminated after two days. He was discharged a couple of times, but readmitted soon afterwards, and was hospitalised continuously as of 15 May 2016.
>
> [The applicant] failed to appear after an agreed temporary leave on 31 May 2016, and it appears from his medical records that he had been in Copenhagen and had been admitted to a psychiatric unit there. On 3 June 2016, he was transferred from the psychiatric unit of Bispebjerg Hospital to the psychiatric unit of Svendborg Hospital for continued hospitalisation. It appears from his medical records that shortly after his arrival [the applicant] became increasingly strained and irritable, threatened the life of employees and assaulted a male employee without any warning by grabbing him around the neck and beating and stabbing him many times in the back of the head.
>
> [The applicant] was restrained with a body belt and straps with the assistance of the police owing to the danger he posed to those around him. At the same time, he was forcibly detained.
>
> Throughout his hospitalisation [the applicant] was described as severely psychotic and easily provoked to aggression and bursts of anger, which clearly took a turn for the worse when he smoked cannabis.
>
> While the mechanical restraint measure was in place [the applicant's] mental state was described as highly unstable and labile and with pronounced psychotic symptoms, in which state he believed that he [had been] well within his rights to defend himself by the assault of 3 June 2016 and [continued to be justified in] throwing coffee, furniture, etc., at staff, whose lives he continuously threatened.
>
> In view of the constant danger he posed to those around him and his severely disordered mental state, which no one had succeeded in stabilising, the chief psychiatrist requested the Ministry of Justice on 9 June 2016 to issue a 'dangerousness decree'.

As, based on a medical assessment, [the applicant] continued to pose an immediate risk of harm to others, it was decided to transfer him to a more secure facility at the Department of Forensic Psychiatry at Middelfart Hospital on 16 June 2016, with him remaining restrained. In connection with the long duration of the restraint measure, prophylactic medical treatment against thrombosis was prescribed and forcibly administered.

As of 7 June 2016, the belt was gradually released for short periods of time in the presence of police officers. Based on the medical assessment that he posed an immediate risk of harm to others, it was deemed reckless to terminate the belt restraint.

On this basis, the Medico-Legal Council will answer the questions asked as follows:

Question 1:

The Medico-Legal Council has been asked to assess whether it was medically correct to continue the mechanical restraint [of the applicant] with a belt until 8.18 p.m. on 16 June 2016, see form 3. In its reply, the Medico-Legal Council has been asked to state whether, based on a medical judgment, it was necessary to continue the mechanical restraint of [the applicant] having regard to the life, health or safety of himself or others.

It is the opinion of the Medico-Legal Council, on the basis of its medical assessment, that [the applicant] continued to pose an ongoing risk to those around him owing to his highly unstable, psychotic state during the relevant period, and it [assesses] that the risk could not have been averted by less intrusive measures.

Question 2:

The Medico-Legal Council has been asked to assess whether it was medically correct to apply straps during the period from 9.30 a.m. on 5 June 2016 to 8.18 p.m. on 16 June 2016.

Yes, reference being made to the initial paragraph and the answer to question 1.

Question 3:

If question 1 or 2 is answered in the negative, whether in full or in part, the Medico-Legal Council is asked to state whether it finds part of the period of restraint to be justified and, in that case, which period.

The question is no longer relevant.

Question 4:

Does the case in general give rise to any comments from the Medico-Legal Council?

No."

33. Before the Supreme Court B.J. gave additional testimony and stated, among other things:

"...The diagnosis of 'hebephrenic schizophrenia with a low IQ score' was schizophrenia beginning at a very early age and being mainly characterised by unpredictable mood swings and incoherent behaviour. This means that it was difficult to know beforehand how the patient would react since the diagnosis was mainly characterised by incoherent behaviour and unpredictability.

...

When reminded of the case notes of 9.30 a.m. and 1.22 p.m. on 5 June 2016, when she had assessed [the applicant] and described him as angry and verbally threatening, the witness stated that the problem had most likely been that his emotions had been very labile all the time. At one moment [the applicant] had threatened to kill and stab the [staff], the next he had laughed for no apparent reason. [His emotions] had simply changed from one hour to the next and that was why she had maintained the mechanical restraint. That was how it had been all the time. As soon as they had tried to control his behaviour, things had gone entirely astray.

At the medical assessment at 10.30 a.m. on 6 June 2016, she had told [the applicant] that she really did not dare to release him, but that she had tried ... all possible ways to find a solution. She had been honest with [the applicant] and had said that from her perspective, she [could not] release him into [the] ward, but that she had tried all other solutions possible. She had also told [the applicant] that she was trying to have the police come so that he could be released at least once a day until they had found another solution. The witness had also met with the hospital management to discuss what they could do. She had also applied for a 'dangerousness decree' and had called the Department of Forensic Psychiatry to ask whether they could help. She had explored all options, as she ... told [the applicant].

The witness was reminded of the following case note of 10.50 p.m. on 6 June 2016 'Wrist and foot straps changed every hour as ordered. Cooperates well until at 10.30 p.m. [and until then] the patient's behaviour is controlled [but] he suddenly turns angry, makes threats and shouts, "my restraining belt must not be tightened, I don't want my mattress sheets changed, I don't care about whom I knocked down", "I wish I had a knife, then I would stab him again!!!"'

The witness stated that this was how they had seen [the episode]. It had occurred without any warning whatsoever. He had suddenly become so angry, so angry. They had seen similar affective reactions when [the applicant] had beaten a fellow patient and had stabbed a fork into the back of the nurse's head.

...

When reminded that it appears from the case note of 2.34 p.m. on 9 June 2016 that she had applied for a 'dangerousness decree', the witness stated that that was the first time that she had applied for such an order. The reason for making the application was that she had considered [the applicant to be] a really dangerous patient whom she did not know what she could otherwise do with. The purpose was to have [the applicant] transferred to the High-Security Psychiatric Ward. From her perspective, [the applicant] had not fitted into a general psychiatric unit and the Department of Forensic Psychiatry had refused [to take him]. [She considered the applicant] a really dangerous patient who belonged in the High-Security Psychiatric Ward. Based on her medical assessment of [the applicant] on that particular day, it [had] continued to be her assessment that there was an imminent risk that he was dangerous.

...

When reminded that it appears from the case note of 4.35 p.m. on 12 June 2016 that they had applied wrist straps [to the applicant] again, the witness stated that [the applicant] had thrown a table and a chair. She had considered the situation so problematic that it had no longer been sufficient to keep the patient restrained with just foot straps and a belt.

She really felt that she had considered whether there were other options than mechanical restraint. She had had at least one and probably ... two meetings with the hospital management to discuss whether they had any other options. However, they had

not been able to identify any. She therefore considered that they had not been able to identify any other alternatives to mechanical restraint in a general psychiatric ward. It had been too dangerous.

She believed that [the applicant] was the most dangerous patient she had ever met. As far as she recalled, and having reread his medical records, the combination of low intelligence, unpredictability, a violent temper, abuse and his criminal and violent history was what had made the patient dangerous. She had been aware from the beginning that he was a very dangerous patient."

34. By a judgment of 26 October 2022, the Supreme Court found against the applicant for the following reasons:

"[The applicant] was mechanically restrained from 1.30 p.m. on 3 June 2016 to 8.18 p.m. on 16 June 2016 while hospitalised at Svendborg Hospital. Like in the proceedings before the District Court and the High Court, he has not disputed the lawfulness of the mechanical restraint until 9.30 a.m. on 5 June.

The issue is then whether the mechanical restraint was also lawful during the following period ending at 8.18 p.m. on 16 June and, if the mechanical restraint was not lawful, the issue is then to [decide to] what extent he is entitled to damages.

The mechanical restraint measure was first applied at 1.30 p.m. on 3 June after [the applicant] had assaulted a male employee at the hospital with a stainless-steel fork, which, according to his medical records, he had stabbed into the back of the employee's head and ... upper back nine times without any warning. It also appears from his medical records that he had lashed out at an employee on two occasions on 4 June and that he had threatened the life or health of staff members on several occasions after 5 June.

The Medico-Legal Council said in its opinion of 25 April 2022, *inter alia*, that [the applicant], who had been diagnosed with severe schizophrenia in 2015, was admitted to the psychiatric unit of Svendborg Hospital on 10 May 2016. After he had beaten a fellow patient without any warning, he was restrained with a belt for two days from 11 May 2016 with the assistance of the police. After a period of hospitalisation at the psychiatric unit of Bispebjerg Hospital, he was transferred to the psychiatric unit of Svendborg Hospital on 3 June 2016 for continued hospitalisation. It appears from his medical records that shortly after his arrival he became increasingly strained and irritable, threatened the life of employees and, as mentioned above, assaulted a male employee without any warning by grabbing him around the neck and beating and stabbing him many times in the back of the head. He was mechanically restrained with a belt and straps with the assistance of the police.

In its written opinion, the Medico-Legal Council also stated that, in the period until 16 June when he was transferred to the Department of Forensic Psychiatry at Middelfart Hospital, [the applicant's] mental state was described as highly unstable and [emotionally] labile with pronounced psychotic symptoms, and that, according to his medical records, he had expressed the view that he had carried out the assault in self-defence. The Medico-Legal Council has also highlighted [the fact] that he had continued to threaten the lives of staff members in the relevant period.

It is the opinion of the Medico-Legal Council that [the applicant], according to a medical assessment, continued to pose an ongoing risk to those around him owing to his highly unstable, psychotic condition during the relevant period, and [it considered] that the risk could not have been averted by any measures less intrusive [than physical restraint].

According to the evidence of B.J., chief psychiatrist, [staff did] consider, *inter alia*, whether remedies other than mechanical restraint were available, but [applying any other remedies] was deemed too dangerous, with the exception that one of the straps on his wrists and feet was unfastened in turn and, at [B.J.'s] request, the police came at least once a day after 7 June to allow [the applicant] to have a shower, a smoke and a walk.

Against this background, the Supreme Court accepts as a fact that [the applicant], who had been diagnosed with severe schizophrenia, posed an ongoing risk of committing unpredictable and aggravated violence on fellow patients and staff from 9.30 a.m. on 5 June to 8.18 p.m. 16 June.

On this basis, the Supreme Court is satisfied that during this period he posed an imminent risk to the life, health or safety of others and that this risk could not [have] be[en] averted by any measures less intrusive than mechanical restraint, which was applied with the ameliorations described. Accordingly, the Supreme Court is satisfied that the conditions set out in sections 4 and 14 of the Mental Health Act for applying mechanical restraint were met. Although it may have been the case that the rules on inspections of restraining belts and assessments by an external chief psychiatrist set out in section 21(4) and (5) of the Act were not observed on few occasions, this cannot lead to the finding that the mechanical restraint was unlawful.

On this basis, the Supreme Court upholds the District Court judgment by which the mechanical restraint of [the applicant] was deemed lawful in its entirety and the claim against the Region of Southern Denmark for payment of damages was dismissed."

RELEVANT LEGAL FRAMEWORK

I. DOMESTIC LAW

A. The Mental Health Act

35. 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*). It, and relevant preparatory notes, were recently set out in *Aggerholm v. Denmark* (no. 45439/18, §§ 39-42, 15 September 2020).

36. Relevant amendments to the Mental Health Act were introduced by Law no. 579 of 4 May 2015. Hereafter, the requirements for the use of restraint, as set out in section 14 of the Mental Health Act, read as follows:

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 briefly and only to the extent that it is necessary to prevent a patient from:

i) exposing himself or others to an imminent (*nærliggende*) risk of harm to body or health,

ii) pestering or otherwise severely intimidating fellow patients; or

iii) doing malicious damage to an appreciable extent.

3. A patient may be compulsorily restrained for longer than a few hours (*få timer*) if justified, having regard to the life, health or safety of the patient or others."

37. The preparatory notes to (the former) 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."

38. The preparatory notes for section 14 (Bill L137, submitted on 5 February 2015 and resulting in amendments introduced by Law no. 579 of 4 May 2015), state that the wording "briefly" in section 14(2) should be understood as "not exceeding a few hours.". Moreover:

"According to the proposed section 14(3), it is stated that the patient may be subjected to coercive restraint for a longer period than specified in the proposed section 14(2) if there are substantial reasons for that, including considerations relating to the lives, mobility and safety of the patient or others. An example of substantial reasons may be that the patient exposes him or herself or others to imminent danger. The indication of danger may exist either as a risk to the person him or herself, typically in the form of a risk of suicide or serious self-harm, or as a risk to others. It is required that the danger be significant. A remote and uncertain risk that the danger will manifest itself is not sufficient. Verbal abuse that does not involve threats of violence or self-harm also falls outside the concept of danger. Reference is also made to the comments on Law no. 331 of 24 May 1989. The purpose is for the proposal to contribute to reducing the use of coercive restraints, especially long-term coercive restraints. In addition, the proposal will be in line with the principles relating to the duration of a coercive fixation set out by the European Committee for the Prevention of Torture (CPT), as stated in section 3.4.2.

..."

The above-mentioned section 3.4.2. in the preparatory notes stated *inter alia*:

"In 2002, 2008 and again in 2014, the Council of Europe's Committee for the Prevention of Torture (CPT) criticised Denmark for the use of prolonged coercive restraint. In the report regarding the 2008 visit, the CPT stated that it 'remains seriously concerned' about the use of prolonged coercive fixations and referred to its report on the 2002 visit, which emphasised that restraint lasting for days has no medical justification and, in the CPT's view, is tantamount to degrading treatment. This was reiterated in the 2014 report. In the report, the CPT sets out the principle that coercive restraint should be used for as short a time as possible, usually only for a few minutes or a few hours. Additionally, the CPT recommends that coercive restraint should only be used in cases where a patient poses an imminent risk of bodily harm or damage to the health of themselves or others, see paragraph 125 of the report on the committee's visit to Denmark from February 4th to 13th, 2014.

Partly owing to this criticism, provisions for increased supervision of coercively restrained patients were included in the revisions of the Mental Health Act in 2007 and 2010.

...

As mentioned in the introduction to the bill, it is also evident from the Government's plan for psychiatry that the proportion of individuals subjected to coercion in psychiatry should be reduced, and [instances of] restraint with belts should be halved by 2020. It is crucial for the government that the use of coercive restraint is reduced both in terms of numbers and duration. It is assessed that there is a need to, among other things, tighten the rules for coercive restraint in order to achieve such a reduction.

It is assessed that it would not be appropriate in the law to set an absolute time-limit on the duration of a coercive restraint, as this could deprive healthcare personnel of the opportunity to provide the necessary care for patients who, after the specified time-limit, still find themselves in the condition that originally led to coercive restraints being applied."

39. Further requirements were set out in sections 15 to 16 of the Health Act:

Section 15

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

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

3. If, in the event of a situation covered by section 14(2)(i), it would be unsafe to await ... the chief psychiatrist, the nursing staff may decide on their own to restrain the patient in question with a belt [in order to ensure] the patient's own safety or the safety of others. In that case, the psychiatrist must be summoned immediately to decide on the use of compulsory restraint with a belt."

Section 16

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

40. Various provisions in the Mental Health Act concern the recording and supervision of compulsory restraint (ibid., § 45), among others:

Section 21

"1. It is the responsibility of chief psychiatrists to ensure that deprivation of liberty and the use of other coercive measures under the provisions of this Act are applied only to the extent necessary.

...

4. As long as the compulsory restraint is continued, a fresh medical assessment must be made of the need for the continued use of mechanical restraint as often as required by circumstances, but at least three times every 24 hours, and such medical assessments must be made at intervals that are evenly spread over the period after the decision on the use of mechanical restraint has been made.

5. If the period of compulsory restraint exceeds 24 hours, an assessment of the continued use of compulsory restraint must be made by a doctor who is not working at the psychiatric unit at which the restraining measure is being applied, who is not in

charge of the treatment of the relevant patient and who does not have a hierarchical relationship with the treating doctor. Such assessment must be made by a doctor who is a psychiatric specialist or a child and adolescent psychiatric specialist. If the two doctors have different assessments of the situation, the treating doctor's assessment will be the final one. The patient must, however, be notified orally and in writing of the two doctors' different assessments of the situation. The Minister for Health and Senior Citizens shall lay down rules on medical assessments under this provision.

6. If the period of mechanical restraint exceeds 48 hours, an assessment of the continued use of mechanical restraint must be made by a doctor who is not working in the psychiatric unit at which the restraining measure is being applied, who is not in charge of the treatment of the relevant patient and who does not have a hierarchical relationship with the treating doctor after 48 hours and on the fourth day after initiation of the measure under the same conditions as mentioned in the second to fourth sentences of subsection (5).

7. Such assessment must be made pursuant to subsections (5) and (6) and must subsequently be repeated once a week for as long as the measure is applied."

41. The frequency of the mandatory medical assessments (including the external assessments) set out in section 21 of the Mental Health Act was modified by Law no. 579 of 4 May 2015. It reduced the frequency of the daily assessments from four to three times per day. The frequency of the external medical assessments was increased so as to be conducted after 24 hours, 48 hours, and on the fourth day of restraint. The weekly external assessments were still to be carried out. From the notes to section 21(5) (Bill L 137 submitted on 5 February 2015) it transpired, *inter alia*:

"... With the proposal, it is emphasised that coercive restraint lasting more than a day is considered to be so prolonged that there is a need for enhanced legal protection guarantees for the affected patients. The proposal will lead to heightened scrutiny after a day of coercive restraint to determine if the criteria for restraint are being met and if there are any alternatives to restraint. The purpose of the proposal is to contribute to reducing the prolonged application of coercive restraint."

42. Sections 34 to 37 of the Mental Health Act concerned the right to appeal and judicial review of compulsory restraint (ibid., § 47). In particular, section 37 sets out as follows:

"1. 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."

43. The following provisions concerned the placement of extraordinarily dangerous persons:

Section 40

"1. In exceptional cases where less intrusive measures are insufficient, the Minister of Justice may decide that mentally ill persons who constantly pose a serious and imminent danger to the life or body of others must be placed in the High-Security Psychiatric Unit at the Department of Forensic Psychiatry of the Zealand region.

2. When a decision has been made under subsection (1), the Minister of Justice must bring the matter before the court within five weekdays for a review under the rules of Part 43a of the Administration of Justice Act.

3. The provisions of this Act apply with the necessary modifications to persons placed in the High-Security Psychiatric Unit under subsection (1). However, this does not apply to sections 5-11, 13, 13d, 13e and 21(2) and to the provisions of Part 10 on the right of appeal and judicial review in respect of decisions on involuntary hospitalisation, forced detention, return or compulsory follow-up after discharge.

4. A patient counsellor is assigned only if the relevant person does not already have a patient counsellor or a guardian *ad litem* under section 71 of the Penal Code (*straffeloven*)."

B. Executive Order no. 1338 of 2 December 2010 on the use of types of compulsion other than deprivation of liberty in psychiatric wards

44. Under the Mental Health Act, the Danish Health Ministry adopted supplementary rules about compulsory restraint in Executive Order no. 1338 of 2 December 2010 on the use of types of compulsion other than deprivation of liberty in psychiatric wards (ibid., § 44).

C. The Medico-Legal Council

45. The rules on the tasks of the Medico-Legal Council and its composition appear in Law no. 60 of 25 March 1961, and Executive Order no. 1068 of 17 December 2001 on the Rules of Procedure of the Medico-Legal Council (ibid., § 48).

46. The authorities may ask the Medico-Legal Council for an opinion in cases before the national courts concerning the use of coercion in psychiatric wards. On 5 October 2017 the Danish Parliamentary Committee on Health and the Elderly put a parliamentary question to the Minister of Justice about the number of cases within the last ten years in which the Medico-Legal Council had been asked for its opinion on the need for the physical restraint of a psychiatric patient, and the proportion of its opinions which were critical of restraints being used in the relevant case. The relevant parts of the answer read as follows:

"... The number of cases in which the Council issued an opinion on physical restraint was arrived at through a manual review of all cases concerning restraint in psychiatry from 2008 onwards [until 5 October 2017]. This revealed a total of 37 cases on the use of physical restraint in that period, as shown below.

In all of the cases listed below, except one, the Medico-Legal Council assessed that use of physical restraint was medically indicated. There is thus only one case in which the Medico-Legal Council considered that the use of physical restraint was not medically indicated.

The Medico-Legal Council notes that it does not issue a critical opinion in such cases, as it is not requested to consider whether medical negligence has occurred. The Council's opinions are based on the questions put to it, which often concern the issue

of whether it is medically indicated to use physical restraint for a given period of time. ...”

D. Statistics

47. In the case of *Aggerholm* (ibid., §§ 49-52), the Government provided a statistical overview of the use of physical restraint in Denmark.

48. 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

49. 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

50. In the present case, the third-party intervener, the Danish Institute for Human Rights, provided the following statistical overview of the use of physical restraint in Denmark.

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
0-2 hours	535	919	781	609	543	445	1,207	861	1,327
2-8 hours	1,291	1,676	1,294	1,155	930	994	1,164	1,270	1,383
8-24 hours	1,717	1,708	1,601	1,326	1,188	1,249	1,474	1,366	1,377
24-48 hours	659	512	464	411	349	333	345	379	317
Over 48 hours	696	513	489	438	436	425	383	333	313
Total	**4,905**	**5,336**	**4,631**	**3,941**	**3,451**	**3,447**	**4,575**	**4,212**	**4,722**

Source: The Danish Health Data Authority

II. RELEVANT INTERNATIONAL MATERIAL

A. United Nations

51. 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) were set out in *Aggerholm* (ibid., § 53).

52. A statement by the United Nations Committee Against Torture from its report of 4 February 2016 (CAT/C/DNK/CO/6-7) regarding Denmark, was set out in *Aggerholm* (ibid., § 54).

53. A statement by the United Nations Committee Against Torture from its report of 18 December 2023 (CAT/C/DNK/CO/8) regarding Denmark, set out among other things:

> "Psychiatric institutions
>
> 36. While the Committee notes the efforts of the State party in recent years to reduce the use of restraint belts in psychiatric settings, the Committee is concerned about information provided by the delegation indicating that, rather than increasing the use of less intrusive measures, forms of chemical restraint are being used instead. The Committee is concerned that the continued persistence of such methods of coercion in psychiatric settings is due, in part, to lack of available human resources. While the Committee notes that the Psychiatric Patient Complaints Board appears to be an effective mechanism, it is concerned over the number of instances in which the Board has found that the initiation or duration of constraint was unlawful, indicating that enhanced training and guidelines and the implementation of existing regulations are required. The Committee is also concerned that children under the age of 15 are not protected by the same legal safeguards as those available to adults and juveniles aged 15 or older, such as the right to a patient adviser and access to complaint mechanisms in cases where parents have consented to the use of coercive measures (arts. 2, 11–14 and 16).
>
> 37. The State party should continue its efforts to reduce recourse to coercion in psychiatric settings and should ensure that physical or chemical means of restraint are used only as a last resort in order to prevent the risk of harm to the individual or to others, and only when all other reasonable options fail to satisfactorily contain that risk. Comprehensive guidelines on the initiation and duration of coercion should be implemented and evenly applied across all psychiatric settings. The State party should ensure that children under the age of 15 are able to avail themselves of the same legal safeguards as adults and juveniles aged 15 or older."

B. Council of Europe

54. 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, were set out in *Aggerholm* (ibid.§ 55).

55. 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 rules on restraining patients in psychiatric establishments (ibid., § 56).

56. An extract on means of restraint in psychiatric establishments for adults, from the 16th General Report (CPT/Inf (2006) 35) was set out in *Aggerholm* (ibid., § 56).

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 (formerly in Nykøbing Sjælland) which receives patients who are considered too dangerous to be placed in other closed forensic or civil units in Denmark. The CPT stressed that means of restraint should only be used as a last resort to manage a 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 124-27 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 stated 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 in 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. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION

63. The applicant complained that his having been strapped to a restraint bed from 9.30 a.m. on 5 June 2016 to 8.18 p.m. on 16 June 2016 had constituted a 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. The parties' submissions

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. The parties' submissions

(a) The applicant

67. The applicant maintained that he had been subjected to physical restraint for longer than absolutely necessary and that the authorities had failed to establish that there had been an imminent risk of danger/harm to the body or health of others requiring his continued physical restraint. He referred to section 14 of the Mental Health Act and to its preparatory notes (including *Betænkning* no. 1109/1987) (see paragraphs 37-38 above), pursuant to which mechanical constraint may only be used "briefly", which is to say for less than a few hours, and that 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. The fact that a patient is considered irresponsible, unpredictable, unwilling to admit blame or potentially dangerous cannot justify the use of restraint. In such cases less intrusive measures, such as personal shielding and sedative medication, increased staff, or other reasonable restrictions on the patient should be applied. He also referred to the findings of the Psychiatric Patients' Complaints Board (see paragraph 10 above) and the High Court (see paragraph 30 above), both of which found that he had been restrained for too long as from 9.30. a.m. on 5 June 2016.

68. He pointed out that at the time a "dangerousness decree" under section 40 of the Mental Health Act had not been issued in his respect, such decrees concerning patients who persistently expose the lives or bodies of others to danger.

69. In the applicant's view his daily records contained no indications at any time that he posed an imminent danger to others, including when he had been released for thirty minutes per day. The fact that he had got more and more frustrated and had had an occasional outburst could not be held against him.

70. The applicant had the impression that it had been decided from the very beginning to keep him restrained during his stay at the ward. He considered that that impression was confirmed by several entries in the daily records, for example that of 9.48 p.m. on Friday 3 June 2016 stating that he "must remain restrained with a belt over the weekend" (see paragraph 14 above) and that of 10.30 a.m. on Monday 6 June 2016 when B.J. stated that

she was "unable to release him" but that she was "struggling very hard to find a solution" (see paragraph 19 above).

71. Moreover, several procedural safeguards set out in section 21 of the Mental Health Act (see paragraph 40 above) had not been complied with when his mechanical restraint had been prolonged. Namely, the 48-hour review had not been carried out by an external psychiatrist but by B.J. (see paragraph 18 above), and on 7, 11 and 15 June 2016 the daily assessments had only been carried out two times per day rather than the (at least) three times required. The applicant contended that such safeguards were statutory minimum requirements which were required to serve as documentary evidence in order to justify the measure in question. Non-adherence to such fundamental safeguards illustrated the arbitrary manner in which the measure against him had been implemented and that his release had been a purely theoretical option.

72. The applicant further considered 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. Referring to the statistics provided (see paragraph 46 above), he submitted that the Medico-Legal Council's "approval-rate" was 97.3% in the relevant period, and concluded that the council had virtually never found that a use of restraint had not been medically indicated.

73. Lastly, the applicant 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 Nations Committee Against Torture, in its report dated 4 February 2016 regarding Denmark, had recommended that the regulations be revised and tightened with the addition of clear and detailed guidance on the exceptional circumstances in which the use of restraint might be allowed.

(b) The Government

74. The Government contended that there had been no violation of Article 3 of the Convention. They concurred with the finding of the Supreme Court in its judgment of 26 October 2022 that the compulsory restraint of the applicant had been proportionate and necessary during the relevant period from 9.30 a.m. on 5 June 2016 until 8.18 p.m. on 16 June 2016 because the applicant had posed an imminent risk to the life, health or safety of the staff and fellow patients in the psychiatric unit and that risk could not have been averted by less intrusive measures than mechanical restraint.

75. The assessment that the applicant had posed a continuous imminent risk to the life, health or safety of others had to be viewed in the light of his mental illness, which was characterised by unpredictable mood swings and

incoherent behaviour, and his previous behaviour, including the incident of 3 June 2016 (see paragraph 6 above).

76. The Government reiterated that the use of restraints had been continued on the basis of thorough and continuous medical assessments and accompanied by continuous monitoring. They referred to the daily records and the statement by B.J. that the applicant had continued to be very emotionally labile, being sometimes quiet and sad and sometimes aggressive, threatening and violent. The applicant had been the most dangerous patient she had ever met, and he had not fitted into a general psychiatric ward. She had therefore lodged an application with the Ministry of Justice for a "dangerousness decree" to have the applicant transferred to the High-Security Psychiatric Unit where extraordinarily dangerous persons are treated.

77. The Medico-Legal Council was also of the opinion that the applicant had continued to pose an ongoing risk to those around him owing to his highly unstable, psychotic state during the relevant period, and that the risk could not have been averted by less intrusive measures. It had therefore found that it had been medically correct to apply straps during the period from 9.30 a.m. on 5 June 2016 to 8.18 p.m. on 16 June 2016.

78. The Government pointed out that the doctors at the unit had used less invasive measures whenever possible. Accordingly, the staff had released the applicant's wrist straps when deemed possible, and they had regularly alternated the wrist and foot straps. Moreover, from 7 June 2016 onwards the police had come for half an hour per day, so that the applicant could be released from the belt, have a shower, smoke and go outdoors.

79. Moreover, a member of staff had kept a constant watch over the applicant throughout the period of mechanical restraint and the staff at the hospital had kept extensive records of all their interactions with the applicant during the period of when he was restrained. In the Government's view, which was in accordance with that of the Supreme Court, the fact that the rules on the inspections of restraints and assessments by an external chief psychiatrist might not have been observed on few occasions could not lead to the finding that the belt restraint had been unlawful.

80. Lastly, the Government reiterated that all the relevant aspects of the case concerning the necessity and proportionality of the measure in question had been reviewed by the domestic courts at three levels of jurisdiction. They had been able to hear testimony from the persons involved and obtain an independent medical opinion 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. Third-party interveners

(a) Dignity – Danish Institute against Torture

81. Dignity – Danish Institute against Torture, which for years has criticised the use of mechanical restraint in psychiatric institutions, noted that the use of such restraints, sometimes for prolonged periods, continued to be common, despite political attention being paid to the matter and there being a goal to significantly reduce use of restraints.

82. It provided information to the Court on the use of mechanical restraint, the amendments to the Mental Health Act introduced in 2015, criticism by international institutions, the health consequences of restraint, and Danish case-law on Article 3 relating to the issue.

83. Dignity advocates for reducing the use of mechanical restraint to exceptional cases only and for as short a duration as possible – in any event not more than 24 hours. Alternatives to consider included increased allocation of resources, training of staff, leadership education, a change of "culture", learning from best practice, detailed regulations and the safe-ward concept.

(b) Danish Institute for Human Rights

84. The Danish Institute for Human Rights provided the Court with information on applicable international human rights standards, Danish law on mechanical restraint, and the use of mechanical restraint in Denmark.

85. It noted, among other things, that the CPT had criticized the fact that under the Mental Health Act, the required external medical review of the justification of the continued restraint (after 24 hours, 48 hours, 4 days, 7 days, and thereafter every week) becomes less frequent the longer the restraint goes on. Moreover, the CPT's recommendation that any use of restraint lasting more than 24 hours should initiate special procedures and actions, such as transferring the patient to a better staffed and more specialised unit or reassessing the diagnosis and treatment, was not reflected in the Act or the guidelines on the use of coercive measures in psychiatry. In their view, Danish law did not contain specific and detailed provisions or safeguards regarding prolonged mechanical restraint.

86. The Danish Institute for Human Rights pointed out that the use of mechanical restraint was still too common at the time of the event in the present case, and that the authorities had so far been unsuccessful in reducing the number of instances of this and other forms of coercive measures.

3. The Court's assessment

(a) General principles

87. 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).

88. 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).

89. 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).

90. 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, §§ 100-01, ECHR 2015).

91. 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).

92. 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 and *Lavorgna v. Italy*, no. 8436/21, § 115, 7 November 2024).

93. 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, §§ 101-03, 18 October 2012).

94. Lastly, the Court has not previously concluded that patients being strapped to a restraint bed for a given period is sufficient, *per se*, to find a violation of Article 3. That will depend on whether the continuation and duration of the measure of physical restraint in respect of the relevant person was the only means available to prevent immediate or imminent harm to him or herself or to others (see *Aggerholm*, cited above, § 105, concerning strapping to a restraint bed for almost twenty-three hours, and compare, *M.S. v. Croatia (no. 2)*, cited above, § 104).

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

95. The applicant did not challenge before the Court the decision of 3 June 2016 to strap him to a restraint bed had been lawful, but maintained that the continuance of the restraint measure from 9.30 a.m. on 5 June 2016 to 8.18 p.m. on 16 June 2016, which lasted eleven days and eleven hours, had been unlawful and in breach of Article 3 of the Convention because the authorities had failed to establish that he had been an imminent risk of danger to others (see paragraph 63 above).

96. The Court will therefore proceed to assess whether the continued application of the restraint measure during the period specified above, and the manner in which it was implemented, 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.

97. It observes that Denmark, partly prompted by criticism, in particular by the CPT, amended the Mental Health Act in 2015 in order to reduce the use of compulsory restraint in general and to establish that it should only be used "briefly" (section 14(2)) (to be understood as "not exceeding a few hours") and that a patient may only be compulsory restrained for longer than a few hours if justified, having regard to the life, health or safety of the patient or others (section 14(3)). The legislator deliberately avoided to set an absolute time-limit on the duration of a coercive restraint, "as this could deprive healthcare personnel of the opportunity to provide the necessary care for patients who, after the specified time-limit, still find themselves in the condition that originally led to coercive restraints being applied" (see paragraphs 36 and 38 above). This also follows from section 21 (6) of the Mental Health Act about supervision of compulsory restraint (see paragraph 40 above). Between 2014 and 2023 the number of cases where

compulsory restraints have been used for more than 24 hours has decreased by more than 50 %.

98. It further reiterates its earlier findings that the legal standards 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 *Aggerholm,* cited above, § 96; *M.S. v. Croatia (no. 2)*, cited above, § 104; and *Bureš*, cited above, § 95).

99. It notes that the necessity and justification of the disputed restraint measure in the present case was assessed on a number of occasions by various administrative and judicial bodies.

100. Firstly, it was reviewed by the Psychiatric Patients' Complaints Board, which on 20 May 2019 (see paragraph 10 above) found that the authorities had failed to show that after 9.30 p.m. on 5 June 2016 there had been a specific, present and demonstrable risk that the applicant was a danger to others. It also found reason to criticise the fact that the mandatory medical assessment after 48 hours on 5 June 2016 had not been performed by an external psychiatrist, but by B.J., the treating chief psychiatrist, and that on more occasions the time span from one medical assessment to the next had been around 12 hours or more, which was not in accordance with section 21 of the Mental Health Act.

101. Thereafter, the disputed measure was reviewed by the courts, when the applicant lodged an application seeking that the State Administration acknowledge having violated his rights under Article 3 of the Convention and pay him compensation.

102. The District Court found the application of restraint to have been lawful (see its judgment of 3 September 2019 quoted in paragraph 29 above). Based in particular on the daily records, which described the applicant as constantly displaying swift changes in his mood from calm to threatening, and the assessments by Chief Psychiatrist B.J, which were approved by several different external psychiatric specialists who performed medical assessments, the District Court found it established that the applicant had been an imminent risk to others throughout the entire period.

103. The District Court did not find that the specific irregularities in complying with section 21(4) and (6) of the Mental Health Act could independently justify the finding that the mechanical restraint should be deemed unlawful. It noted that some of the mandatory medical assessments had not been performed at regular intervals around the clock, but that the staff had considered that it was better to allow the applicant to rest. It also noted that the mandatory 48-hour medical assessment had been carried out by B.J, the treating chief psychiatrist, and not, as required, by an external psychiatrist, but that both the mandatory 24-hour medical assessment and the external assessment on the fourth day had been performed by external psychiatrists,

both of whom had assessed that the conditions for mechanical restraint had been met.

104. The High Court, on the other hand, found that the use of restraint had been unlawful (see its judgment of 6 October 2020 quoted in paragraph 30 above). It had doubts as to whether the medical assessment on 4 June at 1.30 p.m. had been carried out by an external psychiatrist as required. Moreover, it considered that there was a lack of information as to whether the applicant had made verbal threats of violence in connection with the medical assessment at 9.30 a.m. on 5 June 2016 or on previous occasions up until that assessment. Further, since at 9.30 a.m. on 5 June 2016 it had been decided that the applicant should continue to be mechanically restrained with a belt and three straps, and since apart from that no attempt had been made, for example, to release yet another strap and then assess the applicant's behaviour in that situation, the High Court found that the continuation of the mechanical restraint had been unjustified.

105. The Supreme Court found the restraint measure lawful (see its judgment of 26 October 2022 quoted in paragraph 34 above). The Supreme Court gave weight to the opinion of the Medico-Legal Council drawn up on 25 April 2022 (see paragraph 32 above), which found that the applicant had continued to pose an ongoing risk to those around him because of his highly unstable, psychotic condition during the relevant period, and that the risk could not have been averted by any less intrusive measures. It also gave weight to the testimony by the chief psychiatrist, B.J., including her statement that it had been considered whether more lenient measures could have sufficed, but that they had been deemed too dangerous. Instead, the straps on the applicant's wrists and feet were released in turn and, with the assistance of the police, he had been released every day to shower, smoke and go for a walk. The Supreme Court concluded that the applicant had posed an ongoing imminent risk, during the whole period, of committing unpredictable and aggravated violence on fellow patients and staff, and that that risk could not have been averted by less intrusive measures than mechanical restraint, which had been applied with the relaxations described.

106. The Supreme Court found that the fact that the rules on inspections and assessments by an external chief psychiatrist had not been observed on few occasions could not lead to a finding that the mechanical restraint had been unlawful.

107. Turning first to the applicant's complaint that several procedural safeguards set out in section 21 of the Mental Health Act had not been complied with (see paragraph 71 above) the Court agrees with the applicant that the procedural rules on medical assessments set out in the said provision (see paragraph 40 above) were fundamental safeguards. As stated in the preparatory notes to the provision (see paragraph 41 above) these safeguards were inserted because coercive restraints lasting more than a day are considered so prolonged that there is a need for enhanced legal protection

guarantees for the affected patients. It nevertheless notes that although the mandatory 48-hour medical assessment had been carried out by B.J, the treating chief psychiatrist, and not, as required, by an external psychiatrist, both the mandatory 24-hour medical assessment and the external assessment on the fourth day had been performed by external psychiatrists, both of whom had made the assessment that the conditions for mechanical restraint had been met. The Court therefore accepts, in the special circumstances of the present case, that the non-compliance with those rules could not alone lead to a finding that the restraint measure as a whole had been unjustified.

108. Regarding the applicant's complaint that the restraint had lasted for longer than absolutely necessary and that the authorities had failed to establish that there had been an imminent risk of danger/harm to the body or health of others requiring his continued physical restraint, the Court observes that the domestic courts at all three judicial instances made a thorough assessment of whether the applicant had posed an immediate or imminent risk to others at the relevant time, whether his being strapped to the restraint bed had been a proportionate measure and whether the applicant's condition had been assessed and monitored sufficiently. The Court also notes that the medical records show that during the period where the applicant was restrained his behaviour alternated between being calm and apologetic and suddenly lashing out, making threats and throwing objects.

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 *Aggerholm*, cited above, § 109, and *M.S. v. Croatia (no. 2)*, cited above, § 98).

110. It further notes that at the final instance, the Supreme Court, in addition to the evidence already presented, an independent medico-forensic opinion by the Medico-Legal Council was obtained in hindsight (see paragraph 32 above) and the chief psychiatrist, B.J., gave additional testimony (see paragraph 33 above). Based thereon, the Supreme Court concluded that during the whole period of restraint at issue, the applicant had posed an ongoing imminent risk of committing unpredictable and aggravated violence on fellow patients and staff and that the said risk could not have been averted by less intrusive measures than mechanical restraint.

111. The Court reiterates that the applicant was strapped to a restraint bed at 1.30 p.m. on 3 June 2016 because he had assaulted a nurse and that it is not in dispute, or part of the present complaint, that the decision to resort to the restraint measure was "strictly necessary" to prevent an immediate and imminent risk of harm to other persons.

112. While the Court also accepts that the applicant posed an ongoing imminent risk, it is a further requirement that the restraint measure is not prolonged beyond the period during which it was "strictly necessary" (see

paragraph 92 above), and it is for the State to demonstrate convincingly that that condition was met.

113. The Court reiterates (see paragraphs 95 and 96 above) that the relevant period under consideration when the applicant was strapped to the restraint bed lasted for a total of eleven days and eleven hours, until 8.18 p.m. on 16 June 2016, when the measure was formally lifted in order to transfer him first to the Department of Forensic Psychiatry at Middelfart Hospital and thereafter to the High-Security Psychiatric Ward.

114. It notes in particular that chief psychiatrist B.J. considered that the applicant was such a dangerous patient that he did not belong in a general psychiatric ward but should rather be placed in the High-Security Psychiatric Ward, and that she had therefore on 9 June 2016 applied for a "dangerousness decree" (see paragraph 33 above). On the same day, at the weekly external medical assessment, C.BP. wrote: "Given the [circumstances], because we are waiting for the Ministry of Justice's decision to issue a 'dangerousness decree' and since [the applicant] is still deemed to be dangerous to other people, I cannot see that anything can be done other than to have [the applicant] restrained" (see paragraph 25 above). The dangerousness decree was issued by the Ministry of Justice on 23 March 2018 (see paragraph 9 above), and the applicant was transferred to the High-Security Psychiatric Ward on 28 February 2019 (see paragraph 7 above). The Court is not in possession of any information as to why it took the Ministry of Justice so long to issue the dangerousness decree, or why the applicant was not transferred to the High-Security Psychiatric Ward earlier, but it notes that these issues had no direct bearing on the duration of the mechanical restraint at stake in the present case, as the restraint was lifted on 16 June 2016 at 8.18 p.m., when the applicant was transferred to the Department of Forensic Psychiatry at Middelfart Hospital.

115. There is no specific information in the case file either as to why the applicant could not be transferred to the Department of Forensic Psychiatry sooner than 16 June 2016. It is noteworthy in this respect that although in the general psychiatric Unit the application of compulsory restraint against the applicant was the only means available to prevent immediate or imminent harm to the patient or others, and chief psychiatrist B.J. on 6 June 2016 (see paragraph 19 above) wrote that they were "struggling very hard to find a solution for [the applicant]", it nevertheless took eleven days and eleven hours to find such a solution. The Court accepts that a transfer to a more suitable hospital, cannot always, for various reasons, be carried out immediately. It also fully acknowledge that during the period at stake the medical staff, with the extraordinary assistance of the police, attempted to alleviate the applicant's hardship by alternately releasing some of the straps and by releasing him for about thirty minutes per day in order to shower, get outdoors and smoke (see paragraph 21 above) and that as from 14 June 2016 wrist straps were no longer in use (see paragraph 28 above).

116. However, the Court cannot ignore the fact that for more than eleven days after the period of restraint between 1.30 p.m. on 3 June until 9.30 a.m. on 5 June 2016, which the applicant accepts as being justified, the applicant was continuously strapped to the restraint bed. Moreover, a delay which, for whatever reason, causes a prolongation of a patient's compulsory restraint for more than eleven days does not in the Court's opinion sit well with the European and national standards (see paragraph 98 above). Nor does it accord with the specific aim set by Danish legislators in 2015 to reduce the use of compulsory restraint in general, so that it be used only "briefly" (section 14(2)), or their establishing that a patient may only be compulsory restrained for longer than a few hours if justified, having regard to the life, health or safety of the patient or others (section 14(3)) (see paragraph 38 above).

117. In these specific circumstances, the Court cannot conclude that it has been sufficiently proven that the continuation of the restraint measure, given its duration for almost eleven days and eleven 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 *Aggerholm,* § 114, and *M.S. v. Croatia (no. 2)*, § 105, both cited above).

118. It follows that there has been a violation of Article 3 of the Convention on account of the prolonged application of the restraint measure to the applicant owing to the delay in having him transferred to a more suitable institution.

II. APPLICATION OF ARTICLE 41 OF THE CONVENTION

119. 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

120. The applicant claimed 50,000 euros (EUR) in respect of non-pecuniary damage relating to the alleged violation of Article 3 of the Convention.

121. The Government submitted that the claim was excessive.

122. 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 the applicant EUR 20,000 under this head (see *Aggerholm*, cited above, § 119).

B. Costs and expenses

123. The applicant claimed the costs and expenses incurred in the Convention proceedings in the amount of 206,800 Danish kroner (DKK – equal to approximately EUR 27,800), corresponding to legal fees for a total of 70.5 hours of work, carried out by his representative, and to transportation costs in the amount of DKK 4,700 excluding VAT (equal to approximately EUR 630).

124. The Government considered the amount claimed 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).

125. 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 any 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.

126. 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 to awards made in comparable cases against Denmark (see, among others, *Kalkan v. Denmark*, no. 51781/22, § 138, 27 May 2025 [if final]; *Daugaard Sorensen v. Denmark*, no. 25650/22, § 81, 15 October 2024; *El-Asmar v. Denmark*, no. 27753/19, § 88, 3 October 2023; *Aggerholm*, cited above, § 127; and *Tim Henrik Bruun Hansen v. Denmark*, no. 51072/15, § 92, 9 July 2019), and to the fact that the applicant has already received DKK 40,000 under the Danish Legal Aid Act, the Court considers it reasonable to award an additional sum of EUR 6,000 covering the costs for the proceedings before the Court, including the legal fee and transportation costs.

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, to be converted into the currency of the respondent State at the rate applicable at the date of settlement:

(i) EUR 20,000 (twenty thousand euros), plus any tax that may be chargeable, in respect of non-pecuniary damage;

(ii) EUR 6,000 (six thousand euros), plus any tax that may be chargeable to the applicant, in respect of costs and expenses;

(b) 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 31 March 2026, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Hasan Bakırcı Registrar	Lado Chanturia President