ANNUAL REPORT 2018

Period under review

1 January 2018 – 31 December 2018

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FOREWORD

The National Agency for the Prevention of Torture is the body responsible in Germany for ensuring humane detention conditions and treatment of prisoners. The Agency hereby presents an annual report of its activities to the Federal Government, the German *Bundestag*, the *Länder* governments and the *Länder* parliaments. The Report covers the period from 1 January to 31 December 2018.

This document provides a summary of the National Agency's activities in the period under review, as well as background information on the Agency itself, followed by a section on its standards. These concern the main aspects of humane detention conditions and treatment of persons detained in the facilities visited. The standards are derived in particular from recurring recommendations made by the Agency, and are continually developed and adapted. They can also be found on the National Agency's website.

After this follows a report on the National Agency's visits. In 2018, the Agency focussed its activity on the area of residential care and nursing homes. As part of this focus, the National Agency not only conducted visits to relevant facilities, it also contacted important stakeholders in the field. Cooperating with the ministries responsible for this topic was at times problematic as there was not always a willingness to assist the National Agency in fulfilling its legally mandated task.

In addition to the many challenges faced in protecting the human rights and human dignity of persons deprived of their liberty, the Agency also encountered a particular difficulty in its day-to-day work in the year under review. It has become clear that the new budget (having been adjusted in 2015 on account of an increase in personnel) will in the foreseeable future no longer be sufficient for the National Agency to fulfil its mandate. A solution must be found that will enable the National Agency to fulfil its mandate in line with the Federal Republic of Germany's obligations under international law.

Furthermore, the National Agency continues to operate without an adequate legal basis for publishing individual names in its reports on visits to privately owned facilities. As a temporary measure, the National Agency will publish these reports in anonymised form. However, the public often fails to understand the reasons for this. The National Agency already highlighted this issue in its 2017 Annual Report. The Agency believes it is necessary to create an adequate legal basis to enable it to publish the names of all facilities visited as well as all visit reports and opinions, in order to fulfil its preventive duty as provided for in the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (OPCAT).

Finally, in December 2018 the mandates of members Prof. Dr Dirk Lorenzen and Senior Chief Superintendent Hartmut Seltmann (retd) came to an end. The National Agency would like to thank them for the positive contribution they made. Their expertise was a valuable asset for the Agency's work.

Rainer Dopp
State Secretary (retd)
Chair of the Joint Commission

Klaus Lange-Lehngut
Leitender Regierungsdirektor (retd)
Director of the Federal Agency

LIST OF ABBREVIATIONS

CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
ECHR	European Court of Human Rights
EU	European Union
HEAE	Hesse Reception Centre for Refugees in Gießen
NPM	National Preventive Mechanism
OPCAT	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
SGB	German Social Code [*Sozialgesetzbuch*]
SPT	Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
UfA	Detention centre for persons required to leave the country
UN	United Nations

I
SUMMARY

The following provides a brief summary of the National Agency's most important activities. Detailed information on each topic can be found in the individual chapters of this report.

In 2018, the National Agency visited a total of 48 facilities and accompanied four deportation procedures. It met six times in order to discuss standards, recommendations and current developments.

The Agency focussed its activity on the area of residential care and nursing homes. A large number of findings and recommendations were made on this topic, which are presented in Chapter IV. However, the Agency's work on this year's focus topic was not limited to visits to residential care and nursing homes. Together with the Austrian Ombudsman Board – the Austrian National Prevention Mechanism (NPM) – and with the support of the Council of Europe, the National Agency organised for the first time an international NPM conference on the subject of monitoring residential care and nursing homes. The focus of the conference was on the issue of "deprivation of liberty".

The National Agency also contributed to the expert discussions organised by the German Institute for Human Rights at the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth to prepare for and follow up on the 9th session of the *UN Open-Ended Working Group on Ageing*. The latter is a working group set up by the UN General Assembly in 2010 with the aim of strengthening legal protection and formulating specific rights for older people.

In addition, the National Agency established numerous contacts and exchanged views with important stakeholders. For example, the Agency held a discussion with the Federal Government's Nursing Care Representative, State Secretary Andreas Westerfellhaus, as well as talks with the German Association of Care for the Elderly and the Disabled [*Verband Deutscher Alten- und Behindertenhilfe e.V.*], where the aim was to get to know each other and exchange experiences regarding the visits by the National Agency to residential care and nursing homes. The National Agency also took part in specialist events, focussing in particular on measures involving deprivation of liberty in nursing care for the elderly, such as the 7th "Werdenfelser Weg" conference.

In addition to the visits to care facilities for the elderly, visits were also made to Federal and *Land* police stations, to general and forensic psychiatric clinics, to customs and prison facilities as well as facilities for custody awaiting deportation [*Abschiebungshaft*]. In addition, the National Agency accompanied deportations by air from the point of collection until reaching the country of destination. The results of these visits are presented in Chapter V. The reports on the visits are available on the website, partly in anonymised form.

The National Agency strives to have a preventive effect, and therefore endeavours to disseminate and publicise the findings of its activities as widely as possible. To this end, it carried out numerous activities in addition to its regular visits to places of detention and beyond its main topic for the year under review.

On the occasion of the publication of the previous Annual Report, the National Agency once again hosted a reception in Berlin and invited representatives from the facilities it had visited as well as from governmental and non-governmental bodies and further interested parties. There, it gave a detailed presentation of its area of focus in 2017 (deprivation of liberty by the police) and of the most important conclusions drawn from the visits conducted the previous year. In addition, those in attendance had the chance to exchange ideas with other experts. In her welcoming address, Gyde Jensen, Member of the German *Bundestag* and Chair of the *Bundestag* Committee for Human Rights and Humanitarian Aid, emphasised the importance of the National Agency's work. The Annual Report, she stressed, is a call for political action as well as a welcome guideline for the work of parliamentarians.

The National Agency maintains a regular exchange with relevant persons in positions of responsibility, such as the head of the division responsible for the Federal Police at the Federal Ministry of the Interior, Building and Community. As part of plans to remodel the Federal Police custody facilities in Frankfurt am Main, the National Agency was consulted at an early stage and was requested to make recommendations for the structural design of the facility with regard to human rights aspects. It also took part in an event held by the

Commissioner for Refugees, Asylum and Immigration Matters of the *Land* of Schleswig-Holstein, which addressed the case of Oury Jalloh, who died in 2005 in a police station in Dessau.

In the course of its work, the National Agency has found that to ensure the humane treatment of persons deprived of their liberty, it is vital that employees view their profession from a human rights perspective. For this reason, the National Agency further intensified its activities in the field of employee training in 2018. For example, it presented the work it does at the summer course "The European System of Human Rights Protection" at the European University Viadrina in Frankfurt an der Oder.

In the area of police training, existing cooperation with training institutions was intensified and new collaborative schemes were established. At the 21st meeting of the Working Group on Empirical Police Research in Münster, the National Agency reported on its findings and the standards it sets for the humane treatment of persons deprived of their liberty by the police. As part of the project "Political Education and the Police", which is organised jointly by the Federal Agency for Civic Education [*Bundeszentrale für politische Bildung*], the German Police University [*Deutsche Hochschule der Polizei*] and the University of Applied Sciences for Public Administration and Management of North Rhine-Westphalia, the National Agency now offers a training module on the protection of human rights and human dignity in police detention. The aim is to ensure that the findings from ten years of visiting activities are used to inform the way in which police candidates are trained. The Agency's experience should contribute to efforts to raise awareness for human rights challenges in this particular area of police action. Following on from its focus in 2017 on the topic of police detention, the National Agency also took part in the international conference "Fair Treatment of Persons in Police Custody" at Brandenburg Police University. There, it conducted a workshop on the practical challenges encountered in protecting basic rights and human rights during the G20 summit in Hamburg.

A further important activity in 2018 was the international exchange with partner organisations.

The National Agency took part in an NPM conference hosted by the Slovenian NPM, together with the Council of Europe, in Ljubljana on the occasion of its 10th anniversary. The conference focused on how NPMs deal with the issue of assessing the effectiveness and efficiency of their own work.

At the invitation of Austria, the annual exchange of NPMs from Germany, Austria and Switzerland took place in Vienna this year. This regular exchange primarily serves to provide a platform for discussion and to enable the further development of standards. The three NPMs are often confronted with similar challenges, which is why an exchange on various solutions is particularly helpful. The latest meeting focussed on visits to facilities for people with disabilities.

A table in the annex to this report provides an overview of all activities conducted in 2018 that went beyond the National Agency's visits to facilities.

Finally, 2018 also saw a number of changes in the Agency's personnel. The Conference of Justice Ministers appointed the Chair of the Joint Commission, State Secretary Rainer Dopp (retd) as well as three members of the Joint Commission, Dr Monika Deuerlein, Petra Heß and Margret Osterfeld, for a further term of four years. The mandates of members Prof. Dr Dirk Lorenzen and Senior Chief Superintendent Hartmut Seltmann (retd) came to an end at the end of the year. Chief Senior Public Prosecutor Petra Bertelsmeier (retd) and Dr Werner Päckert, *Leitender Regierungsdirektor* (retd), were appointed as new members. 2019 marks the beginning of their mandates.

The present report as well as information on the work of the National Agency may be accessed on the Agency's website.[1] Additionally, the National Agency is also active on social networks[2] where it provides concise information on its work as an NPM to the broader public.

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[1] https://www.nationale-stelle.de/en/home.html
[2] Twitter: "@NationaleStelle", Facebook: "Nationale Stelle zur Verhütung von Folter / NPM Germany"

II GENERAL INFORMATION ABOUT THE WORK OF THE NATIONAL AGENCY

The National Agency for the Prevention of Torture is Germany's designated National Preventive Mechanism. By establishing the Agency, the Federal Republic of Germany fulfilled its obligations under international law following from the OPCAT. The National Agency is only responsible for places where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its explicit consent or acquiescence. The following provides an overview of the National Agency's special status, as well as background information regarding its structure.

1.1 – INSTITUTIONAL FRAMEWORK

The objective of preventing torture and abuse is laid down in the OPCAT, which adds a preventive approach to the UN Convention against Torture of 1984.

Article 3 of the OPCAT requires that the States Parties set up an NPM. These independent national mechanisms engage in preventive measures and assess whether places of detention ensure humane treatment and detention conditions. The National Agency for the Prevention of Torture comprises the Federal Agency for the Prevention of Torture, which is responsible for facilities run at federal level, and the Joint Commission of the *Länder* for the Prevention of Torture, which is responsible for facilities at federal-state level. The Federal Agency and the Joint Commission work together as a National Agency, and closely coordinate their activities.

Under Article 18 of the OPCAT, the States Parties are obliged to guarantee the functional independence of the preventive mechanisms and to make the necessary financial resources available.

The members of the Federal Agency are appointed by the Federal Ministry of Justice and Consumer Protection, while the members of the Joint Commission are appointed by the Conference of Ministers of Justice of the *Länder*. Furthermore, in November 2017 the Conference of Ministers of Justice decided that "in future, civil society organisations should be involved to a greater extent when appointing the members of the Joint Commission of the National Agency for the Prevention of Torture." Consequently, NGOs will be given the opportunity to propose candidates to the Conference of Justice Ministers for positions at the Joint Commission. Members are not subject to supervisory control or legal oversight, and are independent in the exercise of their functions. They act in an honorary capacity. Strict conditions apply for the removal of members before the end of their term in office, as set out in sections 21 and 24 of the German Judiciary Act [*Deutsches Richtergesetz*]. The full-time secretariat is based in Wiesbaden and is affiliated with the organisational structure of the Centre for Criminology [*Kriminologische Zentralstelle e.V.*].

1.2 – TASKS

The principle task of the National Agency is to visit those facilities in which people are deprived of their liberty ("places of detention"), to draw attention to problems there, and to make recommendations and suggestions to the authorities for improving the situation of detainees and for preventing torture and other ill-treatment. Under Article 4(1) of the OPCAT, a place of detention is any place under a State Party's jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its explicit consent or acquiescence.

At the federal level, this definition encompasses all detention facilities operated by the Federal Armed Forces, Federal Police and customs authorities. In addition, the Federal Agency is also responsible for monitoring deportations carried out by the Federal Police. In 2018, a total of 21,059 persons were deported from Germany by air.

The vast majority of facilities fall within the remit of the Joint Commission. These include prisons, *Land* police stations with custody cells, all courts with holding cells, facilities for custody awaiting deportation [*Abschiebungshaft*], psychiatric units in specialist clinics and general hospitals, child and youth welfare facilities with closed units, and homes for people with disabilities. Furthermore, all residential care and nursing homes where measures depriving people of their liberty are or can be enforced are also

classified as places of detention under the above definition.

Further to these activities, the National Agency is also tasked with issuing statements regarding both existing and draft legislation.

1.3 – POWERS

Pursuant to the rules set out in the OPCAT, the Federal Government and the *Länder* grant the National Agency the following rights:

+ Access to all information concerning the number of persons deprived of their liberty in places of detention as defined in Article 4 of the OPCAT, as well as the number of places and their location;
+ Access to all information referring to the treatment of those persons as well as their conditions of detention;
+ Access to all places of detention and their installations and facilities;
+ The opportunity to have private interviews with the persons deprived of their liberty without witnesses, either personally or with a translator if deemed necessary, as well as with any other person who the national preventive mechanism believes may supply relevant information;
+ The liberty to choose the places they want to visit and the persons they want to interview;
+ To maintain contact with the UN Subcommittee on Prevention of Torture, to send it information and to meet with it.

In accordance with Article 21(1) OPCAT, persons who communicate information to the National Agency are not to be sanctioned or otherwise prejudiced in any way. The members and employees of the Agency are obligated to maintain confidentiality with regard to information disclosed to them in the course of their duties. This obligation is to be maintained even beyond the term of their office.

1.4 – PERSONNEL AND FINANCIAL RESOURCES

The National Agency is made up of ten honorary members, and a Secretariat staffed with six full-time employees.

Ever since the Agency was founded, there have been discussions amongst various stakeholders in the field of human rights as well as on the political level as to whether the National Agency's available funding is sufficient for it to fulfil its legally mandated task of regularly visiting over 13,000 facilities and attending measures within its remit involving deprivation of liberty, such as deportations.[3]

The National Agency's budget was increased in 2015 when its staff numbers were doubled. Since then, it has an available budget of EUR 540,000. To date, the budget has not undergone regular adjustments in line with general cost developments. Due to an increase in costs in recent years, particularly in respect of rental payments and personnel, the National Agency was forced to limit its visit activities considerably in 2018. It is already foreseeable that the current budget will no longer be sufficient in 2020 for the Agency to effectively fulfil its legally mandated tasks.

1.5 – ENQUIRIES BY INDIVIDUALS

In the period under review, the National Agency received individual enquiries regarding 45 separate cases that exclusively concerned facilities within the Joint Commission's remit. Although the National Agency is not an ombudsman institute, details provided in individual enquiries are nevertheless of practical relevance for its work. They provide background information for visits, and may draw attention to specific problem areas. In addition, concrete

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[3] CPT/Inf (2017) 13, p. 14; CAT/OP/DEU/1, (16.12013); Follmar-Otto, "*Die Nationale Stelle zur Verhütung von Folter fortentwickeln! Zur völkerrechtskonformen Ausgestaltung und Ausstattung*", policy paper no. 20, 2013, URL: https://www.ssoar.info/ssoar/bitstream/handle/document/34935/ssoar-2013-follmar-otto-Die_Nationale_Stelle_zur_Verhutung.pdf?sequence=1, (available in German only, last retrieved on 29/01/2019); Motion put forward in the *Bundestag* by Bündnis 90/Die Grünen ("*Für den Menschenrechtsschutz in Deutschland – Die Nationale Stelle zur Verhütung von Folter reformieren und stärken*") of 30/05/2017 (*Bundestag* Printed Paper 18/12544)

information and tips can have an influence on which facilities the National Agency visits, and on the priorities it sets as a result.

Where an enquiry contains information regarding serious deficiencies, the National Agency will, with the consent of those concerned, contact the competent authority. If an enquiry provides an indication of a person posing a danger to themselves or to others, the National Agency will also immediately contact the head of the facility concerned.

1.6 – WORLDWIDE TORTURE PREVENTION

The very first preventive mechanism worldwide was the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), inaugurated by the Council of Europe. It was established under the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which came into force on 1 February 1989. The CPT last visited Germany in 2015 and published its corresponding final report in 2017.[4]

The OPCAT entered into force on 22 June 2006. At the start of 2019, it had 103 signatory states and had been ratified by 88 states.[5] The treaty obliges the countries to establish an NPM. To date, 70 States Parties are in compliance with this requirement.[6] In establishing a mechanism, three different models have been followed. In the first model, the remits of existing ombudsman institutes were extended to include tasks concerning the prevention of torture (e.g. in Sweden, Austria and Spain). In the second model, various existing monitoring mechanisms were combined to create an NPM (e.g. in the United Kingdom). A third group of states set up new national preventive mechanisms. This was the case, for example, in France, Germany and Switzerland. However, the resources available to the individual NPMs vary considerably. The French NPM, for example, has over 46 full-time and external monitors, and an annual budget of approximately EUR 5,000,000.[7] Yet it is only responsible for around 5,000 places of detention.[8]

The OPCAT also established the UN Subcommittee on Prevention of Torture (SPT) to operate on an international level. It comprises 25 members, who are nominated and elected by the States Parties. Since 2012, the Subcommittee has been divided into four regional sub-working groups.

The SPT may visit the States Parties for two reasons: Firstly, it may visit places of detention in the States Parties with the aim of making recommendations regarding protecting people deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment. To that end it has essentially the same powers as the NPMs. Secondly, it may also conduct visits to support the States Parties in setting up their NPMs and to offer them training and technical assistance.

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[4] CPT/Inf (2017) 13
[5] Current as of: 08/02/2019, URL: http://indicators.ohchr.org/ (retrieved on 08/02/2019).
[6] Current as of: 08/02/2019, URL: https://apt.ch/en/opcat-database/ (retrieved on 08/02/2019)
[7] Contrôleur générale des lieux de privation de liberté, Annual Report 2016, p. 219 et seqq., URL: http://www.cglpl.fr/wp-content/uploads/2018/11/RA-2016_version-finale_SIG_2_EN.pdf (retrieved on 08/02/2019)
[8] Dessecker / Dopp, "*Menschenrechte hinter Gittern. Kriminologie und Praxis*", vol. 70, 2016, p. 75 et seqq.

III
STANDARDS

The National Agency is tasked with preventing torture and other cruel, inhuman or degrading treatment or punishment at places of detention. This means that it has a preventive remit. For the fulfilment of this task, it is necessary that the Agency's recommendations are implemented not only in the facilities it visits but in all the relevant facilities across Germany. The National Agency translates recurring recommendations into standards. These standards are developed on a continual basis and are intended to provide the supervisory authorities and facilities with benchmarks for humane detention conditions and humane treatment of persons who are deprived of their liberty in any of the facilities under their responsibility. This helps ensure humane detention conditions while also increasing the effectiveness of the National Agency's work despite the large number of facilities. The standards are also published on the website of the National Agency.

To ensure the respect of human dignity, the National Agency considers the following standards to be indispensable.

1 – DEPORTATION

1.1 – TIME OF COLLECTION

Collections at night should be avoided.

1.2 – DEPORTATION FROM PRISON

Where persons who are required to leave the country are currently serving a prison sentence, every effort should be made to ensure they are deported before the end of their sentence. At the very least, it should be ensured that the conditions for deportation are in place before they have fully served their prison sentence.

1.3 – DEPORTATION FROM EDUCATIONAL, MEDICAL, AND CARE FACILITIES

As a rule, deportations should not be carried out from hospitals, schools or daycare facilities.

1.4 – RESPECT FOR THE BEST INTERESTS OF CHILDREN

Families should not be separated as a result of deportation measures. Children should not be shackled. Parents should not be shackled in the presence of their children. If children are deported, there should always be one person who is tasked with ensuring the child's best interests are respected during the deportation procedure. Suitable facilities to keep children occupied should be available at the airport.

1.5 – FURTHER TRAINING FOR PRISON STAFF

Deportations should be carried out by members of staff who are sufficiently qualified and have received adequate further training.

1.6 – LUGGAGE

Every person awaiting deportation must be given the opportunity to pack personal belongings. Steps must be taken to ensure that the person being deported is dressed appropriately for the procedure and for the country of destination, and that identity documents, necessary medication, provisions for children, and any necessary medical aids (e.g. glasses) are packed. One of the persons carrying out the deportation should make sure that luggage is also packed for children being deported. A supply of basic hygiene products and sufficient clothing should be kept at the airport and issued as necessary.

1.7 – CASH LUMP SUM

All deportees must have sufficient financial means to pay for the journey from the airport to their final destination, as well as for meals needed during this journey.

1.8 – INFORMATION ON THE TIME OF EXECUTION OF THE DEPORTATION ORDER

For humanitarian reasons, wherever individual cases require – for example if there are children or sick people in the family – persons required to leave the country should be informed at least a week in advance that their deportation is imminent.

1.9 – INFORMATION ON THE DEPORTATION PROCEDURE

At the time of collection, persons being deported should be provided with information on the deportation procedure. This should be done immediately, comprehensively, in writing and in a language they understand. The information should include the following details:

- The schedule of the deportation including flight times
- Information on luggage
- Information on rights during the deportation procedure

1.10 – COMMUNICATION DURING THE ENTIRE DEPORTATION PROCEDURE

It must be possible for persons being deported and the accompanying prison staff to communicate during the entire deportation procedure. The written information on the person's rights and the schedule of the deportation cannot substitute for the service of an interpreter where communication difficulties arise. Interpreters may also assist via telephone or video conferencing.

1.11 – CONTACT WITH LEGAL COUNSEL

During the deportation procedure, persons awaiting deportation must be allowed to contact legal counsel. Such contact must be made possible at the beginning of the deportation procedure so that any necessary legal measures can be taken in due time. In case the person concerned has so far had no contact with a lawyer, they must be given contact details for emergency legal services.

1.12 – SPECIAL CONSIDERATION FOR CHILDREN AND SICK PERSONS

During deportation procedures, special consideration should be given to the needs of children and sick persons, including any particular care they require.

1.13 – PHONE CALLS WITH RELATIVES

All persons awaiting deportation should be given the opportunity to contact their relatives.

1.14 – MOBILE PHONES

Mobile phones should only be confiscated during a deportation procedure if this is deemed necessary in substantiated individual cases. If circumstances no longer require the confiscation of mobile phones, they must be returned to their owners. Before a mobile phone is confiscated, the person being deported must be given the opportunity to write down important phone numbers.

1.15 – MEALS

Sufficient amounts of food and drink must be available during the entire deportation procedure.

2 – CUSTODY AWAITING DEPORTATION AND CUSTODY TO SECURE DEPARTURE

2.1 – INITIAL MEDICAL EXAMINATION

Every person required to leave the country must undergo an initial medical examination upon admission into custody awaiting deportation [*Abschiebungshaft*] or custody to secure departure [*Ausreisegewahrsam*]. It must be ensured that any indications of trauma or mental illness are diagnosed. In case of communication difficulties, an interpreter should always be called upon to assist in initial medical examinations.[9] For reasons of confidentiality, translations should not be performed by other detainees awaiting deportation. Moreover, if translations are performed by non-medical staff or other detainees awaiting deportation, there is no guarantee that technical terms and subject matter will be correctly translated into the other language.

2.2 – EXTERNAL CONTACT

It should be possible for persons required to leave the country to receive visitors without restrictions, especially relatives. In order to establish or maintain contact with their families and home country, and to facilitate their return, they should also be allowed to use mobile phones and have access to the internet.

2.3 – WORK AND RECREATIONAL ACTIVITIES

It should be possible for persons required to leave the country to make meaningful use of their time. There should be sufficient opportunities to do so every day. This includes access to common rooms, prayer rooms and kitchens where detainees can prepare their own meals.

[9] See part III. 1.10 – "Communication during the entire deportation procedure"

2.4 – VISIBILITY OF TOILETS

Staff members should indicate their presence before entering a cell, especially if the toilet is not partitioned off. The person in the cell might be using the toilet and should be given the opportunity to indicate this.

CCTV cameras must be fitted in such a way that the toilet area is either not visible on the monitor at all or, alternatively, is only shown in the form of pixelated images. If deemed necessary in individual cases, it may be possible to permit unrestricted monitoring of detainees held in specially secured cells due to an acute danger of self-harm or suicide. However, any such decision should be carefully considered, substantiated and documented. If a toilet area is indeed covered by CCTV monitoring and is not pixelated, only persons of the same sex as the detainee should carry out the monitoring.

2.5 – PHYSICAL RESTRAINT

The National Agency defines physical restraint (*"Fixierung"*) as the act of depriving a person of their freedom to move by binding their arms, legs and in some cases the centre of the body, with the result that they are unable to change their sitting or lying position independently. The Agency requires the following conditions be met for the use of this measure:

The use of physical restraints is only to be ordered as a last resort, on the basis of clear and precisely defined criteria, and for the shortest possible period of time. To minimise the risk of physical harm, restraints should be applied using a strap-based system. Persons being physically restrained should, at the very least, be given paper underwear and a paper shirt to wear in order to protect their sense of modesty. The prisoner must also be checked on regularly by a doctor. Persons under physical restraint must also be observed continuously and personally by therapeutic or care staff who are in direct proximity to the detainee (one-on-one

supervision). For any physical restraint applied for more than just a short period of time, a court decision is required.[10] The measure should be discussed with the detainee concerned afterwards.[11] The detainee should also be informed after the measure of the possibility to have a court review the permissibility of the restraint procedure.[12]

Written reasons should be given for every instance of physical restraint. This should include documentation of which less restrictive measures had been tried in advance and why these failed.

2.6 – CCTV MONITORING

CCTV monitoring should only be used in individual cases where it is imperative to protect the person concerned. The reasons for the use of CCTV monitoring should be documented. In addition, the person concerned must be informed that monitoring is taking place. The mere fact that the camera is visible is not sufficient. It should be possible for the person concerned to discern whether the camera is running.

2.7 – CLOTHING

As a rule, persons required to leave the country should be allowed to wear their own clothes.

2.8 – STAFF

The staff of facilities for the enforcement of custody awaiting deportation [*Abschiebungshaft*] or custody to secure departure [*Ausreisegewahrsam*] should be specifically chosen and trained to work in this field.

[10] Federal Constitutional Court, judgment of 24/07/2018, file no.: 2 BvR 502/16, margin no. 69
[11] DGPPN [German Society for Psychiatry and Psychotherapy] (2018): "*S3-Leitlinie: Verhinderung von Zwang: Prävention und Therapie aggressiven Verhaltens bei Erwachsenen*." URL: https://www.dgppn.de/_Resources/Persistent/154528053e2d1464d9788c0b2d298ee4a9d1cca3/S3%20LL%20Verhinderung%20von%20Zwang%20LANG%2BLITERATUR%20FINAL%2010.9.2018.pdf (last retrieved on 27/02/2019).
[12] Federal Constitutional Court, judgment of 24/07/2018, file no.: 2 BvR 502/16, margin no. 85

2.9 – PSYCHOLOGICAL AND PSYCHIATRIC CARE

The facility should make sure that a psychologist or psychiatrist is called in where this is necessary.

2.10 – LEGAL ADVICE

Persons required to leave the country must be given the opportunity to seek legal advice.

2.11 – LEGAL BASIS

The detention conditions of persons in custody awaiting deportation [*Abschiebungshaft*] and custody to secure departure [*Ausreisegewahrsam*] must differ from those of sentenced prisoners.[13] Furthermore, any interference with basic rights beyond the mere placement in such a detention facility requires its own legal basis.[14] Consequently, a specific legal basis must be established for the enforcement of custody awaiting deportation and custody to secure departure.

2.12 – RESPECTFUL TREATMENT

Detainees awaiting deportation should be treated respectfully. For example, staff members should indicate their presence in a suitable manner before entering a room, and should, as a rule, speak to detainees using polite forms of address.

2.13 – PLACEMENT OF MINORS

Unaccompanied minors should not be placed in facilities for the enforcement of custody awaiting deportation or custody to secure departure, but in child and youth welfare facilities. If minors are placed in facilities for custody awaiting deportation or custody to secure departure together with their parents or legal guardians, it must be ensured that such custody takes account of the child's best interests.

[13] Article 16 para. 1 of Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008
[14] Federal Constitutional Court, judgment of 31/05/2006, file no.: 2 BvR 1673/04, NJW 2006, 2093 (2093)

2.14 – WEAPONS IN CUSTODY

In facilities for custody awaiting deportation or custody to secure departure, officers should remove firearms before entering a custody suite.

Due to the significant health risks involved, the use of pepper spray in confined spaces is not a proportionate measure under any circumstances. It should therefore be avoided inside detention facilities.[15]

2.15 – ADMISSION MEETING

An admission meeting must be held with every newly admitted person, during which they should be informed of the reason for their detention. They should also be informed of their rights.

During these meetings, special attention should be paid to any indications of mental illness. If necessary, a psychologist should be involved. For these purposes, the detention facility's staff members responsible for conducting admission meetings must receive specialised training enabling them to recognise signs of trauma or mental illness. In case of communication difficulties, an interpreter must be called upon to assist in admission meetings.[16]

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[15] ECHR, Tali v. Estonia, judgment of 13/02/2014, Application no. 66393/10, margin no. 78; CPT/Inf (2008) 33, margin no. 86

[16] See part III. 1.10 – "Communication during the entire deportation procedure"

3 – FEDERAL AND *LAND* POLICE

3.1 – FURNISHING AND FITTINGS, CONDITIONS IN CUSTODY CELLS

The conditions in police custody cells, including furnishings and fittings, must uphold the human dignity of detainees. Every custody cell should be equipped with a smoke detector, an emergency button, adjustable lighting, a non-flammable, washable mattress, a blanket and a pillow. Where a custody cell is only equipped with a low bed, it should have additional seating at standard height.

To ensure the protection of persons placed in custody in the event of a fire, all custody cells must be equipped with a smoke detector.

In addition, it must be possible for persons deprived of their liberty to call for attention through an emergency button. It must be guaranteed that the alarm system is working. This should be checked before each occupancy of a custody cell.

It should be possible to adjust the lighting in custody cells to ensure that persons taken into custody are able to sleep, while at the same time reducing the risk of injury and enabling detainees to find their way in the dark.

Every custody cell should receive natural light, including those intended for short-term custody. Furthermore, a suitable room temperature should be ensured in custody cells.

3.2 – INSTRUCTION ABOUT RIGHTS

Each and every person deprived of their liberty must be informed of their rights, immediately and without exception. To this end, forms containing all the relevant information should be available in various languages. They must at the very least include information about the fact that anyone who is taken into custody has the right to be examined by a doctor, to consult a lawyer, to notify a trusted third party and, where applicable, inform the consulate of their home country. It should be documented in the police custody record book that the person taken into custody has been instructed about their rights so that it is immediately clear to staff members following a shift change-over whenever the relevant information has not been communicated for any specific reason. If a person was not instructed about their rights when they were brought into custody, this must be done at a later point in time.

3.3 – STRIP-SEARCHES

Strip-searches involving a visual inspection of the prisoner's genital area represent a severe interference with the prisoner's general right of personality.[17] It should therefore be decided on a case-by-case basis whether there are indications of a danger to public security and order that would justify a strip-search. Any such measures must adhere to the principle of proportionality.[18]

If a strip-search is carried out, the reasons for this should be documented in a clear and comprehensible manner. Furthermore, the search should be conducted as respectfully as possible, for example involving two stages where half the body remains dressed in each stage.

3.4 – VISIBILITY OF CUSTODY CELLS

It must not be possible for third persons to look inside a custody cell.

3.5 – VISIBILITY OF TOILETS

Staff members should indicate their presence in a suitable manner before looking through a peephole, especially if the toilet in a custody cell is not partitioned off. The person in the cell might be using the toilet and should be given the opportunity to indicate this.

CCTV cameras must be fitted in such a way that the toilet area is either not visible on the monitor at all or, alternatively, is only shown in the form of pixelated images. Unrestricted monitoring of the custody cell should only be permitted in carefully assessed, substantiated

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[17] Federal Constitutional Court, order of 05/03/2015, file no.: 2 BvR 746/13, margin no. 33
[18] Cologne Administrative Court, 25/11/2015, file no. 20 K 2624/14, juris margin no. 115 et seqq.

and clearly documented individual cases where there is an acute danger of self-harm or suicide. If a toilet area is indeed covered by CCTV monitoring and is not pixelated, only persons of the same sex as the detainee should carry out the monitoring.

3.6 – SHACKLES

In contrast to physical restraint, "shackling", in the National Agency's usage of the term, is the restriction of movement by tying together arms or legs, or by tying them to an object.

Tying persons to the wall or to other objects violates their human dignity and must be avoided without exception.

In order to protect the right to physical integrity, any shackling in custody should be carried out using textile hand restraint belts[19], which should be kept in stock at all times.

3.7 – PHYSICAL RESTRAINT

Physical restraints[20] should not be applied in police stations. The use of physical restraint constitutes a serious interference with a person's liberty, and also presents a serious risk of injury. Physical restraints must therefore be subject to special requirements such as the appropriate and correct application of a strap-based system. The prisoner must also be checked on regularly by a doctor. Persons under physical restraint must also be observed continuously and personally by therapeutic or care staff who are in direct proximity to the detainee (one-on-one supervision). For any physical restraint applied for more than just a short period of time, a court decision is required.[21] The measure should be discussed with the detainee concerned afterwards.[22] The detainee should also be informed after the measure of the possibility to have a court review the permissibility of the restraint procedure.[23]

3.8 – CUSTODY DOCUMENTATION

Custody documentation at police stations should be clear and comprehensible. This serves to protect those being held in custody, as well as the responsible staff members.

The following details should be documented:

- The detainee's personal details
- When the deprivation of liberty began
- The staff members responsible for taking the person concerned into custody and for supervising them during custody
- The health condition of the person concerned
- Whether the person was informed of their rights
- Whether the person was informed of the reason for the deprivation of liberty
- Whether a judicial order had been obtained
- If a strip-search was conducted, the reasons for this
- The name of the staff member conducting the strip-search
- The times of checks, including the initials of the responsible staff member
- The time and type of meals
- The removal and subsequent return of personal objects
- The time of release
- If it was not possible to inform the persons concerned of their rights when they were brought into custody, it should be documented whether this was done at the latest by the time they were released.

Senior officers should check at regular intervals whether the documentation is complete. These checks should be recorded.

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[19] An example of this can be seen in the model used by FRONTEX during deportation flights

[20] See part III. 2.5 – "Physical restraint"

[21] Federal Constitutional Court, judgment of 24/07/2018, file no.: 2 BvR 502/16, margin no. 69

[22] DGPPN [German Society for Psychiatry and Psychotherapy] (2018): "*S3-Leitlinie: Verhinderung von Zwang: Prävention und Therapie aggressiven Verhaltens bei Erwachsenen.*" URL: https://www.dgppn.de/_Resources/Persistent/154528053e2d1464d9788c0b2d298ee4a9d1cca3/S3%20LL%20Verhinderung%20von%20Zwang%20LANG%2BLITERATUR%20FINAL%2010.9.2018.pdf (last retrieved on 27/02/2019).

[23] Federal Constitutional Court, judgment of 24/07/2018, file no.: 2 BvR 502/16, margin no. 85

3.9 – SIZE OF CUSTODY CELLS

Police custody cells must be designed in a way that ensures humane detention conditions.

A single-occupancy custody cell must have a floor space of at least 4.5 square metres. Multiple-occupancy custody cells must have a floor space of at least 3.5 square metres per person.

Facing walls must be separated by a distance of at least two metres, and the ceiling must be considerably higher than two metres.

3.10 – CCTV MONITORING

CCTV monitoring should only be used in police stations in individual cases where it is imperative for the protection of the person concerned. The reasons for the use of CCTV monitoring should be documented. In addition, the person concerned must be informed that monitoring is taking place. The mere fact that the camera is visible is not sufficient. It should be possible for the person concerned to discern whether the camera is running.

3.11 – MULTIPLE-OCCUPANCY OF CUSTODY CELLS

In order to ensure humane detention conditions, it is indispensable that custody cells accommodating more than one person have a completely separate toilet with separate ventilation.

3.12 – RIGHT TO MEDICAL EXAMINATION

Every person taken into custody has the right to consult a doctor.

3.13 – RESPECTFUL TREATMENT

Persons being held in detention should be treated respectfully. For example, staff members should indicate their presence in a suitable manner before entering a custody cell, and should, as a rule, speak to detainees using polite forms of address.

3.14 – INDEPENDENT COMPLAINTS OFFICES AND INVESTIGATION BODIES

An essential element of preventing abuse by staff members is the detection, prosecution and punishment of misconduct on the part of police officers.

Every *Land* should therefore set up independent complaints offices and investigation bodies.[24]

3.15 – CONFIDENTIALITY OF CONVERSATIONS

Persons in custody must be given the opportunity to have confidential conversations with their lawyers. Confidentiality should also be assured for conversations with doctors or relatives.

3.16 – WEAPONS IN CUSTODY

Officers should remove firearms before entering a custody suite.

Due to the significant health risks involved, the use of pepper spray in confined spaces is not a proportionate measure under any circumstances. It should therefore be avoided inside police stations.[25]

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[24] Cf. inter alia ECHR, Kummer v. Czech Republic, judgment of 25/07/2013, Application no. 32133/11 § 83; Eremiášova and Pechová v. Czech Republic, judgment of 16/02/2012, Application no. 23944/04, § 135

[25] ECHR, Tali v. Estonia, judgment of 13/02/2014, Application no. 66393/10 § 78; CPT/Inf (2008) 33, margin no. 86

4 – CHILD AND YOUTH WELFARE FACILITIES

4.1 – POSSIBILITIES FOR COMPLAINT

Children and juveniles must be in a position to submit complaints to a suitable complaint body. In addition to contact persons within the facility, it is important that an external ombudsperson exists who has no ties with the facility.

It must be ensured that children and juveniles can contact such an ombudsperson easily and confidentially. The complaint channels and all necessary contact details should be provided in an information leaflet worded in a child-appropriate manner, or in the facility's house rules, and explained to them when they are first admitted to the facility.

4.2 – OUTDOOR EXERCISE

Every person deprived of their liberty should be offered at least one hour of outdoor exercise per day. Children and juveniles should be offered considerably more time outdoors for exercise.

4.3 – INFORMATION ON RIGHTS

When they are admitted to the facility, children and juveniles must be informed in writing about their rights. This information must be given in a manner that is appropriate to their age.

4.4 – CCTV MONITORING

Children and juveniles should not be subjected to uninterrupted and indiscriminate CCTV monitoring. Under no circumstances can CCTV monitoring replace the presence of members of staff. The reasons for the use of CCTV monitoring should be documented. In addition, the persons concerned must be informed of the monitoring. The mere fact that the camera is visible is not sufficient. It should be possible for the person concerned to discern whether the camera is running.

5 – PRISON SYSTEM

5.1 – CLOTHING WORN IN SPECIALLY SECURED CELLS

When detained in a specially secured cell containing no dangerous objects, prisoners should be given at least a pair of paper underwear and a paper shirt to wear.

5.2 – STRIP-SEARCHES

According to the Federal Constitutional Court, strip-searches involving a visual inspection of the prisoner's genital area represent a severe interference with the prisoner's general right of personality.[26] It is not permissible to carry out strip-searches routinely and without case-specific suspicions.[27] To satisfy this requirement, general strip-search orders must allow for exceptions if the principle of proportionality so demands. Staff must be made aware that in individual cases it may not be necessary for the prisoner to undress fully.

If it is indeed necessary that the prisoner undress fully, then the search should be conducted in a respectful procedure, for example involving two stages where half the body remains dressed in each stage.

5.3 – SHOWERS

Persons who have been deprived of their liberty should be given the opportunity to shower alone if they wish to do so. At least one shower should be partitioned off in communal shower rooms.

5.4 – VISIBILITY OF TOILETS

Staff members should indicate their presence before entering a cell, especially if the toilet is not partitioned off. The person in the cell might be using the toilet and should be given the opportunity to indicate this.

CCTV cameras must be fitted in such a way that the toilet area is either not visible on the monitor at all or, alternatively, is only shown in the form of pixelated images. If deemed necessary in individual cases, it may be possible to permit unrestricted monitoring of detainees held in specially secured cells due to an acute danger of self-harm or suicide. However, any such decision should be carefully considered, substantiated and documented. If a toilet area is indeed covered by CCTV monitoring and is not pixelated, only persons of the same sex as the detainee should carry out the monitoring.

5.5 – SOLITARY CONFINEMENT

To mitigate the negative impact of solitary confinement on mental and physical health, detainees should be provided with sufficient opportunities for human contact (e.g. extended visiting times) and to engage in meaningful activities. Those placed in solitary confinement are also to be seen regularly by a psychiatrist or psychologist. This should take place in a suitable and confidential environment.

5.6 – PHYSICAL RESTRAINT

The use of physical restraints[28] is only to be ordered as a last resort, on the basis of clear and precisely defined criteria, and for the shortest possible period of time. To minimise the risk of physical harm, restraints should be applied using a strap-based system. Persons being physically restrained should, at the very least, be given paper underwear and a paper shirt to wear in order to protect their sense of modesty. The prisoner must also be checked on regularly by a doctor. Persons under physical restraint must also be observed continuously and personally by therapeutic or care staff who are in direct proximity to the detainee (one-on-one supervision). For any physical restraint applied for more than just a short period of time, a court

[26] Federal Constitutional Court, judgment of 5/03/2015, file no.: 2 BvR 746/13, juris margin no. 33–35

[27] Federal Constitutional Court, judgment of 10/07/2013, file no.: 2 BvR 2815/11, margin no. 16, with reference to ECHR, van der Ven v. the Netherlands, judgment of 4/2/2003, Application no. 50901/99, § 62

[28] See part III. 2.5 – "Physical restraint"

decision is required.[29] The measure should be discussed with the detainee concerned afterwards.[30] The detainee should also be informed after the measure of the possibility to have a court review the permissibility of the restraint procedure.[31]

Written reasons should be given for every instance of physical restraint. This should include documentation of which less restrictive measures had been tried in advance and why these failed.

5.7 – CELL SIZE

In order for detention conditions to be humane, a single-occupancy cell must have a floor space of at least six square metres, excluding the sanitary area. In cases where the sanitary area is not partitioned, approximately one further square metre should be added for that area, giving a total floor space of at least seven square metres. For multiple-occupancy, a further four square metres of floor space must be added to this figure for each additional person, excluding the sanitary area.

5.8 – CCTV MONITORING

CCTV monitoring in prisons should only be conducted in individual cases where this is imperative to protect the person concerned. The reasons for the use of CCTV monitoring should be documented. In addition, the person concerned must be informed that monitoring is taking place. The mere fact that the camera is visible is not sufficient. It should be possible for the person concerned to discern whether the camera is running.

5.9 – MULTIPLE-OCCUPANCY CELLS

According to the case law of the German Federal Constitutional Court[32], prison cells accommodating more than one person must have a completely separate toilet with separate ventilation. Multiple-occupancy without such a separation constitutes a violation of human dignity.

5.10 – USE OF SEGREGATION UNITS

In addition to the specially secured cells containing no dangerous objects, facilities may also have segregation units with similar furnishings and fittings. In such cases, the same detention conditions must be applied as for the specially secured cells. Furthermore, comprehensive documenting must be carried out, in line with procedures for specially secured cells.

5.11 – RESPECTFUL TREATMENT

Detainees should be treated respectfully. This includes staff indicating their presence in a suitable manner before entering the prison cell, and speaking to detainees using polite forms of address.

5.12 – PEEPHOLES

With the exception of observation rooms, peepholes should be made opaque in order to protect the privacy of the detainees.

Should peepholes be deemed necessary in substantiated individual cases, staff members should make themselves heard before looking through the peephole.

5.13 – INTERPRETATION DURING MEDICAL CONSULTATIONS

Confidentiality must be assured for medical consultations, which are subject to medical secrecy. Furthermore, it must be ensured, where necessary, that technical terms and subject matter are adequately translated into the other language. In case of communication difficulties,

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[29] Federal Constitutional Court, judgment of 24/07/2018, file no.: 2 BvR 502/16, margin no. 69

[30] DGPPN [German Society for Psychiatry and Psychotherapy] (2018): "*S3-Leitlinie: Verhinderung von Zwang: Prävention und Therapie aggressiven Verhaltens bei Erwachsenen*." URL: https://www.dgppn.de/_Resources/Persistent/154528053e2d1464d9788c0b2d298ee4a9d1cca3/S3%20LL%20Verhinderung%20von%20Zwang%20LANG%2BLITERATUR%20FINAL%2010.9.2018.pdf (last retrieved on 27/02/2019).

[31] Federal Constitutional Court, judgment of 24/07/2018, file no.: 2 BvR 502/16, margin no. 85

[32] Federal Constitutional Court, order of 22/02/2011, file no.: 1 BvR 409/09, margin no. 30

an interpreter[33] must be called upon to assist. Translation by fellow inmates or any of the facility's non-medical staff is not appropriate.

5.14 – HANDLING CONFIDENTIAL MEDICAL INFORMATION

In order to ensure medical information is handled confidentially, details concerning infectious diseases, for example, should only be recorded in medical files and not in prisoner files. This ensures that only medical personnel are made aware of such information, and not general prison staff.

5.15 – CONDITIONS IN PRISON CELLS

In prisons, inmates should have access to natural, unfiltered light in their cells. Their view outside may not be obstructed by opaque plexiglass panes, for instance.

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[33] See part III. 1.10 – "Communication during the entire deportation procedure".

6 – PSYCHIATRIC CLINICS

6.1 – OUTDOOR EXERCISE

Every person deprived of their liberty should be offered at least one hour of outdoor exercise per day. Children and juveniles should be offered considerably more time outdoors for exercise.

6.2 – DOCUMENTATION OF COERCIVE MEASURES

All coercive measures should be documented comprehensively, comprehensibly and completely. The measure must be documented in writing. This includes documenting which less severe measures have already been tried and an explanation of why they failed.

6.3 – PHYSICAL RESTRAINT

The use of physical restraints[34] is only to be ordered as a last resort, on the basis of clear and precisely defined criteria, and for the shortest possible period of time. Persons under physical restraint must be observed continuously and personally by therapeutic or care staff who are in direct proximity to the detainee (one-on-one supervision). For any physical restraint applied for more than just a short period of time, a court decision is required.[35] The measure should be discussed with the detainee concerned afterwards. [36] The detainee should also be informed after the measure of the possibility to have a court review the permissibility of the restraint procedure.[37]

[34] See part III. 2.5 – "Physical restraint"
[35] Federal Constitutional Court, judgment of 24/07/2018, file no.: 2 BvR 502/16, margin no. 69
[36] DGPPN [German Society for Psychiatry and Psychotherapy] (2018): "*S3-Leitlinie: Verhinderung von Zwang: Prävention und Therapie aggressiven Verhaltens bei Erwachsenen*." URL: https://www.dgppn.de/_Resources/Persistent/154528053e2d1464d9788c0b2d298ee4a9d1cca3/S3%20LL%20Verhinderung%20von%20Zwang%20LANG%2BLITERATUR%20FINAL%2010.9.2018.pdf (last retrieved on 27/02/2019)
[37] Federal Constitutional Court, judgment of 24/07/2018, file no.: 2 BvR 502/16, margin no. 85

6.4 – INFORMATION ON RIGHTS

Patients must receive written information on their rights in the psychiatric facility. Where young people are concerned, this information should be provided in an age-appropriate form.

6.5 – CCTV MONITORING

Persons held in psychiatric facilities should not be subjected to uninterrupted and indiscriminate CCTV monitoring. Under no circumstances can CCTV monitoring replace the presence of members of staff. The reasons for the use of CCTV monitoring should be documented. In addition, the person concerned must be informed that monitoring is taking place. The mere fact that the camera is visible is not sufficient. It should be possible for the person concerned to discern whether the camera is running.

6.6 – RESPECTFUL TREATMENT

Patients should be treated respectfully. For example, staff members should indicate their presence by knocking on the door before entering a room, and should, as a rule, speak to patients using polite forms of address.

6.7 – CONFIDENTIALITY OF CONVERSATIONS

In psychiatric facilities, measures should be introduced to ensure that phone calls can be made confidentially.

IV FOCUS: RESIDENTIAL CARE AND NURSING HOMES

1 – INTRODUCTION

In the year under review, the National Agency chose to focus on the topic of residential care and nursing homes.

Since commencing its visits to residential care and nursing homes in 2015, the National Agency has visited such facilities in every *Land*. In the reporting period, it carried out 28 visits to residential care and nursing homes, three of which were follow-up visits. The latter were arranged in order to assess the extent to which the facilities had implemented recommendations from previous visits.

To ensure humane conditions in care facilities, it is vitally important that patients are able to lead as self-determined a life as possible, regardless of the severity of their care needs. Where it is not possible to avoid certain limitations, these must be kept to a minimum level of what is strictly necessary. The visits addressed in particular the issues of: measures for deprivation of liberty; ensuring maximum freedom of choice for patients in all matters; protection against violence; respectful treatment of residents; as well as general conditions in the facilities, for example in terms of accessibility.

The present report draws on findings from all visits conducted to date to residential care and nursing homes.

1.1 – THE NATIONAL AGENCY AS A PREVENTIVE MECHANISM IN RESIDENTIAL CARE AND NURSING HOMES

The National Agency conducts visits to residential care and nursing homes with the aim of preventing potential violations of human dignity in places where people are deprived of their liberty. The Agency works together with the facilities and the highest supervisory authorities in order to bring about sustainable improvements in living conditions.

However, in a small number of cases, the facilities visited stressed that residential care and nursing homes are already inspected by various control mechanisms, and it was therefore not clear why further inspection was necessary.

Nevertheless, the National Agency is in fact obliged to include residential care and nursing homes in its visits. This mandate follows from Article 2 (1) of the State Treaty on the establishment of a national mechanism of all *Länder* in accordance with Article 3 of the OPCAT, which obliges the National Agency to conduct visits to “places of detention” within the meaning of Article 4 of the OPCAT. This concerns all places where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its explicit consent or acquiescence. This includes long-term care facilities, as persons may be deprived of their liberty in being accommodated there, or may be subject to measures involving deprivation of liberty.[38] These facilities may be either public institutes or privately owned.

The Medical Service of the Health Insurance Funds [*Medizinischer Dienst der Krankenkassen*] and residential home authorities are also tasked with inspecting residential care and nursing homes. There is therefore potential for overlaps in individual assessment criteria. Yet what differentiates the inspections is their particular focus. In its visiting activities, the National Agency is concerned with humane conditions. Consequently, any overlaps with other inspection mechanisms will only arise where the focus is on ensuring the human dignity of residents. Given this focus, it is often necessary for the National Agency to express criticism over circumstances that are not addressed, or not addressed sufficiently, in other inspections.

1.2 – COOPERATION WITH THE RESPONSIBLE MINISTRIES

The responsible ministries must enable the National Agency to fulfil its mandate. This implies a number of obligations for those ministries. However, in isolated cases, the ministries responsible for residential care and

[38] Nowak / McArthur, The United Nations Convention against Torture – A Commentary, 2008, p. 926, margin no. 2

nursing homes have failed to comply with these obligations.

For example, the ministries are obliged to grant the National Agency access to all places of detention and their installations and facilities (cf. Article 20 (c) OPCAT). This obligation also requires that the ministries inform the facilities concerned about the National Agency and its powers, and make them aware of the fact that visits may occur at any time and without prior notification.

In Baden-Württemberg, however, this was not always the case. When it was announced to one residential care and nursing home that a visit would take place the following day, the facility stated to the Ministry of Social Affairs and Integration of Baden-Württemberg that it would not grant admission. The facility had not received any information concerning the National Agency up until that point. The responsible Ministry of Social Affairs and Integration of Baden-Württemberg found that it was unable to arrange for the National Agency to access the facility at the planned time. Consequently, the facility was visited at a later date.

Furthermore, the ministries are obliged to grant the National Agency access to all information referring to the treatment of persons deprived of their liberty in places of detention as well as their conditions of detention (cf. Article 20 (b) OPCAT).

In order to make as little extra work as possible for the facilities on the day of the visit, the National Agency allows them to submit certain information relevant to the visit after the date. Two of the facilities visited failed to comply with this subsequent obligation and did not send the National Agency the requested information. The ministries responsible for these facilities were the Ministry for Social Affairs and Integration of Baden-Württemberg, and the Brandenburg Ministry for Labour and Social Affairs, Health, Women and Families. These ministries, as the highest supervisory authorities, did not consider themselves in a position to take measures enabling the National Agency to fulfil its statutory mandate – despite their legal obligation to do so.

According to Article 22 of the OPCAT, the ministries are required to examine the recommendations of the National Agency and enter into a dialogue with it on possible implementation measures. For the National Agency to be effective in its task of preventing inhumane treatment, it is essential that the highest supervisory authorities give independent consideration to the recommendations it makes.

In compliance with this legal obligation, the respective ministries usually issue clear statements on each individual recommendation made by the National Agency. However, the Saarland Ministry for Social Affairs, Health, Women and Families merely informed the National Agency that all aspects addressed in the report had been clarified or settled, and that for staffing and organisational reasons it would not be issuing a detailed statement. On occasion, the competent ministries referred the National Agency to the residential home authority as a point of contact, even though only the highest supervisory authorities in the country can ensure that the recommendations of the National Agency are implemented.

During a follow-up visit to a facility in Baden-Württemberg, it was also noted with concern that some of the recommendations made had not been implemented, contrary to assurances from the ministry in its statement on the report on the first visit.

1.3 – JUDICIAL DECISIONS

During each visit, the National Agency consulted the judicial decisions at hand concerning measures involving deprivation of liberty. This revealed considerable differences in the legal assessment of individual measures involving deprivation of liberty. Furthermore, the reasons for certain decisions were not always clear, while in isolated cases there were considerable doubts as to the lawfulness of judicial decisions.

The National Agency found that the application of identical measures was assessed at times as a deprivation of liberty and at other times as a mere protective measure. Such discrepancies were observed even in cases involving judges of the same court, and even in the same circumstances. This was noted, for

example, in regard to the use of a sensor wristband that triggers a signal to employees when the wearer leaves the facility so that the employees can return the resident to the facility immediately.

In response to repeated applications for authorisation to use bed rails, the custodianship judges of Köthen Local Court issued a joint letter with the general statement that "the protective measures used in the homes of the court district to prevent persons from falling out [of a bed] do not constitute measures requiring authorisation, since they merely offer protection against falling out without restricting the freedom of the persons concerned." One facility that the National Agency visited in October 2018 had also received this general statement of 7/07/2014. The facility stated that, as a result of the letter, it had ceased to apply for authorisation from a court in such cases, and had since then applied measures such as the use of bed rails without judicial authorisation or consent from the person concerned. The local court's legal assessment disregards the fact that even bed rails can constitute a measure involving deprivation of liberty.[39] It also goes against the statutory obligation not to decide on measures in a generalised manner, but rather to ensure a case-by-case assessment. The National Agency considers the court's action in this regard to be highly questionable.

The competent court repeatedly ruled that there was no obligation to acquire authorisation to apply a measure involving deprivation of liberty due to the presumed immobility of the persons concerned.

[39] Palandt/Götz, "*BGB-Kommentar*" [Commentary on the German Civil Code], 76th ed., sections 1906 margin no. 35

A measure involving deprivation of liberty within the meaning of section 1906 (4) of the German Civil Code [*Bürgerliches Gesetzbuch*, BGB] is deemed to exist if, *inter alia*, the physical freedom of movement of the person concerned is restricted by the measure in question. "This is the case if it cannot be ruled out that the person concerned would be capable of a voluntary change in their location, but would be prevented from making such a change by the measures in question."[40] A person who is at risk of falling and injuring themselves when making voluntary movements cannot be considered immobile.

In many cases, the court decisions were not based on a medical certificate proving the person's state of immobility. In addition, it appeared that, contrary to section 319 (1) of the Act on Proceedings in Family Matters and in Matters of Non-contentious Jurisdiction [*Familienverfahrensgesetz* – FamFG], the courts had not obtained a personal impression of the local situation in each individual case. The justification for the decisions merely referred to information or statements provided by third parties, such as a guardian. In the justification given for one decision, it was stated that authorisation for mounting a bed rail was no longer necessary because the guardian had stated that the mother in question no longer moved.

Unlawful and contradictory judicial decisions lead to legal uncertainty in the facilities concerned. It would therefore be desirable to have a consistent approach in place that is in line with the relevant law. Equally, clear justifications should be provided.

[40] Federal Court of Justice, order of 27/06/2012, file no.: XII ZB 24 / 12, margin no. 10

2 – VISITS

2.1 – POSITIVE EXAMPLES

The National Agency highlighted several positive examples during its visits. These included:

Architectural aspects

Some facilities were designed in such a way that there were routes through the building that formed complete circles with no corridor ends. This enabled persons with dementia, for example, who may have a strong need for movement and exercise, to leave their living area and then independently find their way back again.

Activities and social participation

As the majority of residents in the facilities are women, the activities on offer were often more targeted towards female residents. However, one facility also offered activities that were mainly suited to men's interests, such as operating electric model trains.

One facility offered a walk outside its premises each day. This was arranged at the same time every day and could be attended by any residents who were interested, and without the need to register for the activity in advance. Offering activities like this gives residents the opportunity to engage in outdoor exercise on a daily basis. It can also alleviate the feeling residents might have of being cut off in the facility from the outside world.

In order to organise additional care options on a regular basis for the residents, one facility maintained a close cooperation with the voluntary organisation "*Grüne Damen*" [Green Ladies].

For over ten years, one facility has taken a group of residents each year on holiday for a week to the Baltic coast accompanied by the facility's own staff. This gives residents with care needs a break from day-to-day life in the facility.

Daily life

In some of the facilities visited, residents had their own personal letterbox, which they could access independently. This afforded the residents greater independence in daily life.

Several facilities allowed the residents to participate voluntarily in day-to-day activities such as setting the table, folding laundry or tending the garden. This enabled them to have a more active role in daily life in the facility.

Staff

In a number of facilities, a carer had been appointed as an officer for measures involving deprivation of liberty. Their task was to assess any proposed measures within the facility that would involve deprivation of liberty as to whether they were necessary in each individual case, and whether all possible alternatives had been exhausted. In some cases, these officers had been specifically trained to develop alternative options to measures involving deprivation of liberty to suit particular situations, and thereby reduce the use of such measures.[41]

A number of facilities employed care staff with an additional qualification in palliative care. This can help increase awareness around care situations where palliative measures should be used so that the persons concerned receive the right attention for their particular needs.

In a number of facilities, ethical case reviews were held to discuss particular difficulties in caring for residents and to develop strategies for use in future. Certain facilities also offered further training on the topics of dealing with mental illness and stress management. Measures

[41] Training on "Guardian *ad litem* – the "Werdenfelser" approach" [*Verfahrenspfleger nach Werdenfelser Weg*]. The so-called "*Werdenfelser Weg*" is a procedural approach under the applicable law on adult guardianship that aims to improve decision-making processes concerning measures involving deprivation of liberty. In this way, the ultimate goal is to reduce the frequency and severity of measures involving deprivation of liberty

of this kind can help staff to become more confident in dealing with challenging situations, while at the same time reducing the level of stress they experience personally in such situations.

Care and support for persons with dementia

In a number of facilities, tactile reliefs had been mounted on the walls in the living areas for residents with dementia in order to stimulate their haptic perception.

To support residents with a cognitive disability, one facility had brought in several dogs, including trained therapy dogs. The initiative helped to improve interaction with those residents.

As part of its overall care concept, one facility had established a fundamental approach whereby the residents could do as they pleased as long as their actions did not harm themselves or others. To facilitate this, a carer was available at the reception area in addition to the administrative employees. Whenever a resident with a severe cognitive impairment wishes to leave the premises on their own, that carer is able to intervene and attend to the resident appropriately. This allows the residents to structure their day with a significant degree of autonomy, while also limiting stress for both the residents and the staff members.

Legal aspects

Two facilities had displayed large, clearly legible posters on the walls, which explained residents' rights. These provided residents, family members and visitors with relevant information in easy to understand language.

2.2 – FINDINGS AND RECOMMENDATIONS

2.2.1 – Medical care

In one facility, a resident's request to be examined by a doctor in a specific matter was not granted. Not only could this have health consequences, it also violates the resident's right to physical and psychological integrity. All express requests by residents to receive medical treatment should be granted.

One facility had stated in its overall care concept that medical decisions on prescribed measures should be viewed by staff members as direct orders. The concept, however, did not state that the patient must first have given their effective consent to undergo medical treatment. Guidelines such as this could be misinterpreted, while their implementation has the potential to violate the residents' right to self-determination and physical integrity. Medical treatment based solely on an agreement between a carer and a doctor without the effective consent of the person concerned is not permissible. Staff guidelines must be in line with legal provisions.

Not all facilities offered opportunities for basic medical check-ups. For example, in several facilities there was no cooperation with an ophthalmologist. As a result, regular eye check-ups did not take place. Good vision has a fundamental effect on a person's ability to perform a number of tasks, such as orientating oneself and walking steadily, as well as generally leading an independent life. Medical care in the facilities should be organised in such a way that any deteriorations in health are largely prevented or at least detected at an early stage so that appropriate measures can be taken.

2.2.2 – Furnishings and design

In the residents' rooms in one facility, the only lighting available was the ceiling light; there were no smaller lights, for example above the beds. This inconvenience was all the greater for persons sharing a double room. The furnishings in residents' rooms should include additional lighting above their beds. This not only allows residents to read etc. whilst in bed, it also offers a less disruptive light source at night, for example when residents go to the toilet or require nursing care.

In one of the facilities visited, several areas did not seem especially homely and had a rather gloomy atmosphere. The corridors, for example, were dark due to a lack of natural light. In the communal areas, the radios and televisions were not plugged in. There was also a bad smell in several areas. The residents' kitchen appeared to be used as a storage room for boxes and decorations. Residential care and nursing homes are the primary domestic environment of the residents who live there, and should be designed

accordingly. Facilities should provide communal areas that offer a pleasant environment where activities are organised and the residents are able to engage socially with each other or with visitors.

2.2.3 – Accessibility

In several facilities, thresholds had been fitted in the doorways to the balconies and outside areas with the result that residents in wheelchairs could not go outdoors without assistance. This also entails the risk that residents might trip on a threshold. In one facility, the doorway to the balcony was covered with construction sheeting and a prohibition sign was displayed due to a faulty locking mechanism. However, this had been the case for a long period of time. Indeed, the residents had been unable to use the balcony for approximately half a year. The staff of the facility, however, regularly used the balcony to smoke, and temporarily removed the construction sheeting to do so.

In some facilities, patient lifts, nursing trolleys and wheelchairs had been placed in the corridors, resulting in restricted passageways. This posed a significant impediment in particular to any persons who are reliant on a mobility aid.

In a different facility, toilets that had been designated as handicapped-accessible had been designed in such a way that it was not possible for persons in a wheelchair to use them independently. As well as this, the mirrors in the sanitary areas seen during the visit had in some cases been mounted so high up on the wall that persons in a wheelchair would be hardly able to see them.

Residents should be able to live as independently as possible, without the obstruction of physical barriers. Barrier-free access should be guaranteed to all areas intended to be used by the residents, including the outdoor areas.

Yet the issue of accessibility is not limited to building aspects alone. Access to sources of information and the availability of communication devices are further factors in ensuring accessibility. In individual facilities, it was noted that information that had been displayed for the residents and their family members on topics concerning everyday life, such as activities or church services, were difficult to read and at times unclear. Facilities should ensure that up-to-date and easy-to-read information is provided in full to the relevant target group.

2.2.4 – Accessing advice and making complaints

Numerous facilities failed to display contact details for the responsible supervisory authority and external complaints bodies. Furthermore, in certain facilities there did not appear to be any effective form of complaint management in place.

In order to effectively protect residents from violations of their rights, it should be possible for them, their family members, and their legal representatives to access information about their rights as well as aspects of the running of the facility that concern them. They should also have the opportunity to make complaints if necessary. To this end, they should be made aware of complaints channels in an appropriate manner. This could be done, for example, in the form of an easy-to-read notice with contact details in every living area. Residents should be supported in making complaints, both orally and in writing, as well as anonymously.

2.2.5 – Activities and social participation

In several facilities, the number and range of activities on offer were insufficient. Planned activities were repeatedly cancelled and there were often no activities offered at weekends. Some facilities stated that there were not always enough staff members available to allow residents to take part in activities outside of the facility. The reason for this was that many of the residents needed a wheelchair to leave the facility, which would require one staff member per person. However, facilities should enable every resident to participate in social life, and should also support them in doing so.

Residential care and nursing homes should offer daily activities to suit different target groups. These should be spread throughout the day. It should be borne in mind that persons with dementia in particular have limited to

severely limited abilities to engage independently in meaningful activities. It is therefore important that facilities offer activities that are tailored to the interests and abilities of these persons.[42] Facilities must also take into account that some residents may have a strong need for movement and exercise.

In some facilities, bedridden residents were socially isolated and only received individual care a few times a week for a period of up to half an hour. Furthermore, it was also noted that the room of one bedridden resident entirely lacked surrounding stimuli such as images or scents etc. The National Agency is of the opinion that the conditions encountered were insufficient. Social isolation and the lack of stimulus can cause or intensify psychopathological changes, which can result in a significant deterioration of health and quality of life for those affected. It was therefore feared that residents' rights to physical and psychological integrity had not been sufficiently respected. Appropriate measures must be taken to ensure there are sufficient stimuli in the residents' rooms.

At one of the facilities visited, the nearest bus stop was approximately one kilometre away. This made it difficult for visitors travelling by public transport to access the facility. Yet it also made it more difficult to bring residents, for example, on a trip to the city centre and thereby ensure social participation. Facilities should be adequately connected to public transport.

2.2.6 – Fire protection

In isolated cases, some residential care and nursing homes were found not to have smoke detectors, while in others the installed smoke detectors were not working. In several cases, facilities had not developed their own individualised fire safety concept to provide employees with concrete instructions in the event of a fire, for example on how to conduct an evacuation. It was also repeatedly found that nursing trolleys or wheelchairs had been placed in the corridors, thereby blocking the escape route.

Residential care and nursing homes should be fitted with smoke detectors. It is also advisable for facilities to have guidelines in place for responding in the event of a fire, as well as to train all staff members accordingly. Escape routes must be kept clear.

2.2.7 – Privacy of correspondence

In one facility, it was observed that individually named letter boxes were positioned in the corridors for delivering post to all residents living in that section of the facility. As these letter boxes were open, it was possible for unauthorised persons to access their content. It is therefore to be feared that the privacy of the persons concerned is not being adequately protected. Facilities must take precautions to protect residents' inviolable right to privacy of correspondence.

2.2.8 – Nutrition

In many residential care and nursing homes, the residents stated that they were not satisfied with the meals served. These statements were echoed in the facilities' written complaints registers. Complaints concerned in particular a lack of variety of the meals served, too small portions, and poor quality. In one case, persons requiring assistance at meal times were not fed individually. The facility explained that this was due to a lack of staff. In a further facility, it was found that not all residents were aware of the option of having a late evening meal. As a result of this, the residents concerned complained that the time span between dinner and breakfast was too long.

An imbalanced diet and too small portions can lead to nutrient deficiencies and result in health consequences. Furthermore, too long a wait between meal times can cause acute health complications in particular in people with diabetes mellitus or dementia.

The meals served in residential care and nursing homes should meet the requirements of nutritional guidelines for the elderly.[43] All

[42] Federal Ministry for Family Affairs, Senior Citizens, Women and Youth; Federal Ministry for Health (ed.): "*Charta der Rechte hilfe- und pflegebedürftiger Menschen*", [Charter of rights for persons requiring assistance and care], Article 6, version of: March 2015

[43] *Deutsches Netzwerk für Qualitätsentwicklung in der Pflege* [German Network for Quality Development in Care

residents should be aware of the option of having a late evening meal.

2.2.9 – Further training courses

On several occasions, certificates relating to further training for employees showed that a time slot of only 20 minutes was provided for topics such as "deprivation of liberty", "emergency call training" or "fall management – best practice".

Further training should be designed to promote professional standards of care and support. A reasonable amount of time should therefore be available for training.

2.2.10 – Deprivation of liberty

Consent

In the case of several residents, measures involving deprivation of liberty (such as bed rails) were taken at the resident's own request. However, various shortcomings were identified in connection with the consent required for such measures:

In some cases, the consent had been given in writing several years previously, yet the facilities had not subsequently acquired renewed consent at regular intervals. In other cases, the facility could not find evidence of acquired consent at the time of the visit. In numerous cases, documentation on consent was incomplete. For example, facilities had not always informed residents of the possibility to revoke consent at any time, or what alternative measures were available – or at least any such steps had not been documented. In one case, details such as the resident's living area and room number were not recorded, which could lead to the incorrect application of a measure involving deprivation of liberty if two residents within the same facility had the same name. Consent was also found to measures involving deprivation of liberty that were no longer being applied. No dated and signed notice of cancellation was available. In one facility, it was reported that consent was requested orally every day before the measure was applied, although this was not documented.

One facility used a form for obtaining consent that included the notice that a witness's signature was required for residents who were capable of giving consent but incapable of providing a signature – and that the witness should be a permanent employee. Such a requirement gives the impression that the person concerned is not free to choose who acts as their trusted person in such matters. This entails the risk that the person concerned may feel under pressure, and that their right of self-determination could be violated.

In several facilities, the opinion was expressed that lowerable beds offer a viable alternative to other measures involving deprivation of liberty. However, if persons are unable to stand up independently from a lowerable bed once it has been lowered, this may constitute a measure involving deprivation of liberty. This would therefore require the consent of the person concerned, or a court permit.

The installation of bed rails or the lowering of a lowerable bed may constitute a measure involving deprivation of liberty within the meaning of section 1906 (4) of the German Civil Code [*Bürgerliches Gesetzbuch*, BGB]. In principle, it is possible for the persons concerned to consent to such measures. However, this requires that the persons concerned are capable of giving consent in a specific decision-making situation, that their consent was recent, and that they have been informed about alternatives as well as the possibility of revoking their consent. This should be documented in a transparent manner. Furthermore, persons who have given such consent should be asked at regular intervals (e.g. every three months) whether their declaration still applies. The response should be documented, dated and signed by the resident to confirm the validity of the declaration.

Absence of judicial authorisation

In one facility, it was found that the placement order for one resident had already expired a week prior to the visit. However, the person remained in a living area where the exit door was locked and could only be opened by employees. In another facility, it was found that bed rails

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Services] (ed.): *"Expertenstandard Ernährungsmanagement zur Sicherung und Förderung der oralen Ernährung in der Pflege"*, 1st update 2017; *Deutsche Gesellschaft für Ernährung e.V.* [German Nutrition Society]: *"DGE-Qualitätsstandard für die Verpflegung in stationären Senioreneinrichtungen,"* 3rd edition, 2015

were in use in certain cases without court permits or consent from the persons concerned. When asked about this, the facility replied in a particular case that the person concerned was immobile. However, there was no medical certificate to confirm this. Nor was the facility able to provide any explanations for the other cases. A further case was observed where a bed rail was still in use even after the relevant court order had been annulled. The facility had continued to use the bed rails for a period of more than two years before consent was obtained from the person concerned.

As a fundamental principle, every human being has a right to personal freedom. In accordance with section 1906 of the German Civil Code [*Bürgerliches Gesetzbuch*, BGB], the placement of a person in a closed living area against his or her will and the application of measures involving deprivation of liberty require judicial authorisation, unless there are exceptional circumstances in the particular case that would justify such a measure, or the person concerned has expressly given consent.

Preventing residents from leaving a living area

In several facilities, measures were found that were designed to prevent residents (in particular those with dementia) from leaving a living area or facility without the exit door having to be locked.

Such measures included, for example, number code locking mechanisms on exit doors or lifts. It was also seen in many facilities that the exit doors were covered with curtains, colourful blinds or printed wallpaper so that they would not be immediately recognisable as exits. In other facilities, certain residents were equipped with transponders, which would set off a ring tone whenever the resident opened the door of the living area. The facilities explained that when a ring tone is activated, the employees run to the door to prevent the residents from leaving the living area or the facility.

Generally in these cases, no placement orders or orders for measures involving deprivation of liberty had been issued by the courts.

The National Agency sees this as a threat to the civil liberties of the persons concerned.

In many cases, the facilities did not recognise that preventing residents from leaving an area could constitute a deprivation of liberty. Deprivation of liberty does not only arise where there are absolute obstacles such as locked doors.[44] Covering a door in the manner outlined above has the result that residents are unable to recognise the exit due to their reduced cognitive abilities. If the act of concealing the exit has the effect that an individual is under the impression that it is physically impossible to leave the area they find themselves in, then this constitutes a deprivation of liberty within the meaning of section 1906 of the German Civil Code [*Bürgerliches Gesetzbuch*, BGB].[45] The same applies to complicated locking mechanisms or any other method whereby staff prevent individuals from leaving a particular area.[46]

It must be ensured that measures involving the deprivation of liberty are applied in accordance with legal requirements at all times.

Procedure instructions for deprivation of liberty

In one facility, the procedure instructions on measures for the deprivation of liberty did not comply with legal requirements in several respects. As a consequence, there was a danger that legal provisions might not be observed when residents were being deprived of their liberty.

In order to prevent violations of residents' rights of personality, procedural instructions for employees must comply with the relevant laws.

2.2.11 – Violence prevention

In some facilities, it appeared that the topic of violence had not been sufficiently addressed. No central record was kept to document violent incidents between residents or between residents and staff. Furthermore, some facilities had no violence prevention strategy.

The topic of violence should be discussed openly in order to raise awareness among

[44] Walther, "*Freiheitsentziehende Maßnahmen nach § 1906 Abs. 4 BGB*", BtPrax 6/2005, p. 215; Jacobs, "*Freiheitsentziehende Maßnahmen nach § 1906 Abs. 4 BGB durch optische oder verbale Täuschung*", BtPrax 2012, vol. 3, p. 99; Stalinski, "*Unterbringungsähnliche Maßnahmen - § 1906 Abs. 4 BGB*", BtPrax 2/2014, p. 58
[45] Ibid.
[46] Palandt/Götz, "*BGB-Kommentar*" [Commentary on the German Civil Code], 76th ed., sections 1906 margin no. 35

employees and to prevent incidents. Practical instructions for dealing with and documenting violence should also be devised. In addition, further training is advisable on suitable procedures in critical situations, such as de-escalation. For violence prevention in the long term, it is also helpful to record incidents of violence centrally and to evaluate them on a regular basis. This makes it possible to identify developments over a long period of time and, if necessary, to take countermeasures.

2.2.12 – Protection against infection

In some facilities, it was observed that the nursing staff's protective clothing was dirty. Indeed, some staff members in the facilities visited wore no protective clothing at all, even though this was required for carrying out certain care measures. Furthermore, in two of the facilities visited, several residents carried bacteria such as MRSA[47] or Clostridia. Despite this, the protective measures required in such situations were not properly implemented. In light of the practices observed, there is a danger that employees could spread germs and that, as a result, residents are not adequately protected from infections.

Facilities must take measures to ensure effective protection against infection.

2.2.13 – Medication

In many of the visited facilities, shortcomings were found with regard to the provision of medicine. These concerned the documentation of medication, the legality of medication and the administration of medicines.

Documentation

Shortcomings were repeatedly found with regard to the clarity and completeness of documentation. The prescription date, for example, would often be missing or overwritten, making it unclear from which date the prescription was valid. Furthermore, the discontinuation of medication was not fully documented in some cases, which made it impossible to gain an overview of the current situation. In several other cases, the name of the doctor who prescribed the medication was not recorded, thereby removing the possibility of targeted consultations.

Shortcomings in the documentation of medication can jeopardise the patients' right to physical and psychological integrity. All documentation of medication must make clear when each specific medicine was prescribed and the name of the doctor who prescribed it. It should also specify when the medicine should be distributed or administered as well as the required dosage. Similarly, orders by a physician to discontinue a particular medication must also be clearly documented. Entries should always be signed by the person documenting the information.

In many cases, facilities did not meet the additional requirements for documenting needs-based medication, as they did not clearly document the reason why the medication was required. For instance, some of the scenarios cited as requiring psychotropic medication included "in case of anxiety", "for unusual behaviour" or "if needed". As for the needs-based administration of painkillers, information such as "for pain" or "for any kind of pain" was provided. In two cases, it was stated that painkillers are administered for up to five days before a doctor is called if the pain persists. In one case, the documentation for a particular resident specified three types of psychotropic drugs as being needs-based. The resident had brought this medication with her upon admission, but had not needed it at all since then. There were therefore doubts as to whether this medication was still necessary, and whether the stated application would still be appropriate if the need arises in the future.

If information regarding the reasons for needs-based medication is missing or inaccurate, it is left to the on-duty caregivers to decide whether a particular situation warrants the administration of such medication. Prescribing pharmaceutical products and specifying when they ought to be used are the responsibility of a doctor. To ensure that needs-based prescription medication is administered in accordance with the therapy intended by the doctor, both the prescription and the associated documentation must be unambiguous. Facilities should strive to meet the requirements for prescribing needs-based

[47] Methicillin-resistant Staphylococcus aureus

medication in order to ensure that treatment is provided safely. Needs-based medication should also be reviewed on a regular basis.

Legality

In cases where the person concerned was unable to provide consent, almost all of the facilities only retrospectively involved the guardians responsible for health care in changes of treatment and medication or did not involve them at all. In only a few cases did this comply with the guardian's wishes. Some facilities only informed the guardian in the event that an order was given by a psychiatric or neurological specialist. In one facility, the delegation was told that the facility did not cooperate with guardians on the subject of health care. As a result, it was unclear whether valid consent had been provided for changes in treatment and medication. In cases where the affected person had provided consent personally, this was not documented. Likewise, there was no documentation stating that affected persons were demonstrably able to provide consent in the decision-making situation.

The practices encountered in these facilities illustrate that, in the majority of cases, there is no guarantee of the protection that guardianship aims to provide against treatment or medication being given without legally valid consent. In the view of the National Agency, this constitutes a risk to residents' right of personality.

A guardian is appointed to actively represent the interests of the person concerned towards third parties in accordance with their assigned area of responsibility. This also applies to appropriately authorised representatives. In the event that the affected person is unable to give consent, legal representatives must be informed of any changes in treatment or medication ahead of time by the attending physician; a decision should then be taken on this basis. In addition to communicating the purpose of any changes in treatment or medication, a comprehensive explanation should include reasoning, potential effects and alternatives. Facilities should make this possible by establishing appropriate workflows and documenting consent.

Where the person concerned is capable of giving consent in a specific decision-making situation, they can take the decision themselves. In such cases, the capacity of the person concerned to provide consent should be documented in a clear and comprehensible manner.

Administration of medicine

As regards the administration of medicine, the National Agency observed mix-ups, omissions, and a lack of compliance with the appropriate regulations. On multiple occasions, tablets for specific residents were ground together before being administered so that the resulting powder could be given to the person concerned either with their food or via a feeding tube. This occurred even when the information provided by the drug manufacturer stated that the medication in question should not be crushed.

Omissions and mix-ups in the distribution of medication can endanger the health of residents or cause life-threatening situations. This also applies to cases where improper administration alters or negates the effect of the medication. Certain foods, such as milk or fruit juices, can also alter the effects of a drug. Thus, as a general rule, facilities should refrain from mixing medication into residents' food.

In order to prevent damage to health, it must be ensured that residents receive only the medication that has been prescribed to them, and that it is administered as prescribed by the doctor. Regulations on the administration of medication must be adhered to.

2.2.14 – Residents' participation

Several facilities did not have any kind of residents' committee at the time of the visit. In several cases, a residents' advocate acted on behalf of the residents without the facility having encouraged the formation of a residents' committee. In addition, it was repeatedly stated in the facilities that the residents' committee did not have its own separate meeting. In two cases, the residents' committee complained that management was not sufficiently approachable.

The participation of residents in matters related to the facility's operation can help to safeguard their rights and ensure that dignified care and support is provided. The participation of residents should therefore be encouraged in order to prevent such issues from arising.

Facilities must adhere to statutory provisions in this area.

2.2.15 – Emergency exits

In isolated cases, the National Agency found that it was difficult to identify the emergency exits as doors due to a variety of measures such as printed wallpaper or curtains. Furthermore, the door handles in one facility had been installed in an unusual way.

Facilities must ensure that emergency exits are clearly recognisable as such so that they can be used without delay during an emergency. Due to the aforementioned optical illusion and the unusual door handles, this was not guaranteed in the facilities in question. Residents might therefore be in danger in case of an emergency.

2.2.16 – Emergency calls

The recommendations concerning emergency calls referred primarily to residents' ability to access the emergency call bell, the bell's functionality, and staff reaction times after the emergency call has been made.

It was noted in one facility that the emergency call bells above residents' beds were sometimes too high for residents to reach while lying down. In spite of this, the required extension was either not made available to all affected residents or its position did not enable the emergency call bell to be triggered. One facility justified this by stating that, in the opinion of care staff, the residents in question were unable to use the bell correctly. The rooms were subject to regular visual checks. The intervals for these checks were stated as being between 30 minutes and two hours. As these inspections were not documented, there was no way of verifying that they actually took place. Residents in several facilities reported that they frequently had long waiting times before staff would respond to an emergency call. Waiting times of up to half an hour were reported in some cases.

Residents must be able to attract the attention of staff and request assistance when required. This means that emergency call bells must always be functional and accessible to residents (via an extension if necessary). Regular visual checks are no substitute for the ability to make an emergency call when needed. Once the emergency bell has been triggered, staff should respond as quickly as possible in order to avoid causing unnecessary stress or potential injury to the person concerned.

2.2.17 – Staff

On the subject of staff, the National Agency's recommendations primarily concerned availability, communication skills, qualifications and professional expertise.

There were complaints in several facilities regarding insufficient availability of staff, as well as persistently high staff turnover and sick leave. In some cases, this led to shortcomings in the level of care provided to residents, including a failure to provide body care, deficiencies with regard to hygiene, long waiting times after triggering the emergency bell, and key services being provided unreliably or not at all. In one case, a resident called the fire brigade on a weekend to inform them that she had been lying in her own faeces for several hours without receiving care. On another occasion, the residents' committee of the same facility contacted the National Agency with a call for help, stating that the facility was severely understaffed and the residents were worried they might not receive adequate care. A subsequent review of the facility, which was carried out by the competent Ministry once it had been made aware of the issue, confirmed the residents' fears.

Several facilities employed temporary staff in order to offset staff shortages. According to the facilities, this included people with insufficient German language skills. This could jeopardise the provision of appropriate and correct care and support. It must be ensured that communication is possible between staff and residents – as well as between members of staff themselves.

On specific night shifts, specialist caregivers were frequently outnumbered by non-specialists. In one facility, it was reported that non-specialist staff providing care and support did not receive sufficient instruction or that they received no instruction at all. In addition, it was stated that no reviews were conducted of their work performance. Such practices give rise to concerns that residents could be harmed. Temporary staff should only be employed under

the instruction and supervision of specialist care and support staff.

According to information provided by the visited facilities, the proportion of residents with dementia in a particular facility was often significantly more than half. Despite this fact, many facilities did not have any specialist care staff with a supplementary qualification for gerontological psychiatry. There is therefore a danger that the care and support provided to residents with dementia might not cater sufficiently to their particular needs.

In individual cases, it was doubtful whether all members of staff were sufficiently suited to their role of working with persons in need of care. An inspection of the complaints records, for instance, revealed evidence of inappropriate treatment by staff towards residents, poor staff morale, theft of money and jewellery, and night-time disturbances caused by staff living at the facility.

In order to ensure that the care and support provided by a facility is tailored to the individual needs of its residents, strong relationships between residents and caregivers are essential. This means maintaining a certain level of staff consistency and a sufficient calibre of personnel, both in terms of their qualifications and their professional ethics. It should be ensured furthermore that communication between caregivers and residents is not hindered by language problems. Frequent changes in personnel and the repeated employment of temporary staff are highly detrimental both to the individuals requiring care and the members of staff themselves. Additional training and management by specialist care staff is required in such cases, which then reduces the time available for carrying out specialist tasks. Furthermore, in order to ensure that care and support is provided appropriately and correctly, staff working conditions must be such that permanently excessive workloads and high levels of sick leave are avoided.

2.2.18 – Care and support

In a few facilities, basic services were provided inadequately – in some cases with major delays – or were not provided at all. This included providing residents with body care, ensuring that individuals requiring care remain in their beds, neglecting to change dirty clothing, quickly handing over food to persons requiring assistance while eating, as well as giving meals to individual residents in a disorganised manner or not providing them at all.

The right of residents to psychological and physical integrity must be guaranteed. It must therefore be ensured that necessary services are provided reliably, at the correct time and to the required standard.

Care records

The National Agency found gaps and errors during an inspection of the care records. The biography page, for example, was sometimes missing, or prescribed medication was documented incorrectly. Furthermore, it was repeatedly found that care-related information was recorded both electronically and in paper form. However, some of the information was only recorded in one of the two systems. This can mean that not all of the information available at the facility is taken into consideration when needed. If care-related data are stored across different systems, it must be ensured that both of the systems are accessed (e.g. via cross-referencing).

In one facility, documents concerning admission, enduring powers of attorney and adult guardianship were only available in the administrative department. As a result, specialist care staff did not have unhindered access to these documents from the living areas. In order to prevent erroneous decisions when providing care and support, documents of this nature must be available at all times to the persons responsible for the care process.

During an inspection of one facility's documentation, it was found that "resident suffers from dementia" was documented in one case, and "forgets this very often because of her dementia" was documented in another. "Dementia" was not listed under the medical diagnoses in either of these cases. In the view of the National Agency, it is not acceptable to document "dementia" in cases where a resident shows signs of forgetfulness, for example. This approach gives rise to concerns that the self-determination of those affected could be restricted for no reason.

Care scheduling

At the time of the visit to one facility at the end of June 2018, the care schedules were missing for all individuals in need of care who had been admitted since the beginning of the year. It is doubtful whether targeted care and support can be provided under these circumstances. In another facility, the care team did not hold group discussions regarding care scheduling. Certain issues relating to care and support were only discussed during monthly team meetings. The transfer of information was not organised seamlessly for all staff involved in providing care and support.

If care and support is not based on a pre-determined schedule or agreed upon by members of the care team, vital measures may be neglected. As a result, the extent to which affected persons are dependent on care may remain unnecessarily high or even increase. The process of providing care and support to individual residents must be planned at an early stage, implemented in a professional manner and adjusted on a regular basis.

Incontinence care

The National Agency repeatedly observed shortcomings in the care provided to incontinence sufferers, which resulted in a strong urine smell emanating from the affected residents. In addition to providing genital hygiene care and suitable incontinence products, a change of underwear may also be necessary in order to ensure that incontinence sufferers receive a standard of care that takes into account their individual needs while also respecting their human dignity. An insufficient standard of care can potentially cause skin damage and lead to the affected person being ostracised from the community because of their smell.

Care of persons with catheters

As regards the care provided to individuals with an indwelling urinary catheter, it was observed in isolated cases that leg bags were attached without a cover and in a location visible to third parties. Discretion should also be taken into consideration in order to provide dignified care and support.

2.2.19 – Self-determination

In some of the visited facilities, residents were restricted in their right to self-determination.

One facility, for example, preferred to admit individuals who already had an adult guardian. Those without an adult guardian were required to grant enduring power of attorney to relatives or other trusted persons so that they could make decisions in certain pre-determined areas when necessary. In fact, enduring power of attorney was enacted by the facility at the same time as the affected person moved in. Thus, the authorised persons were immediately noted as the main contact person for all matters relating to the resident in question. This approach runs counter to the purpose of enduring power of attorney and carries the risk of effectively denying the affected person their right to make decisions.

Residents' right to self-determination and an independent lifestyle must also be respected in matters relating to their everyday lives. Some facilities, for example, only permitted smoking outside of the building. This is particularly problematic for residents with insufficient personal mobility and in adverse weather conditions. Measures should be introduced to allow smoking inside the facility – particularly if the residents are not merely visiting the facility but are in fact permanently resident there.

2.2.20 – Fall prevention

A large number of facilities did not carry out – or did not comprehensively document – personalised and goal-oriented fall prevention for residents at risk of falling. The statistics kept in one facility recorded a total of 77 falls, documenting "serious injury" as the outcome in 18 cases and "hospitalisation" as the outcome in 13 cases. It was concluded on the basis of these statistics that "the increased number of falls is due to the deliberate decision to avoid measures involving deprivation of liberty and thereby provide residents with the greatest possible degree of freedom". However, this conclusion ignores the fact that an increase in the number of falls can also be caused by inadequate fall prevention measures.

Ensuring and maintaining personal mobility is crucial to an independent and self-determined

lifestyle. For this reason, facilities must respect the right to move freely while simultaneously preventing the risk of potential falls. Facilities should ensure that a comprehensive and personalised fall prevention programme is in place for all residents, and that the latest findings in the field of medical care are taken into account. Furthermore, the implementation of fall prevention measures should be subject to regular review. In order to minimise the risk of falls, it may be useful to regularly conduct a central evaluation of fall analyses and to take appropriate action where necessary.

2.2.21 – Over-occupancy

During its visits, the National Agency observed over-occupancy in isolated cases. Since the available personnel, premises and services in residential care and nursing homes are all based on the intended maximum occupancy, over-occupancy must be avoided.

2.2.22 – Dealing with dying and death

In one facility, it was common for dying residents living in a double room to be moved out of their previous living environment and into an alternative room.

Any person who requires care and assistance has the right to die with dignity. People who are dying should not be forced to leave their familiar surroundings.

V
VISITS

1 – DEPORTATION

In 2018, the National agency observed the following four deportation procedures:

- 31/01: Leipzig/Halle to Tunisia
- 29/05: Frankfurt to Albania and Kosovo
- 21/08: Berlin-Tegel to Ghana
- 24/09: Frankfurt am Main to Pakistan

The immigration authorities of the respective *Länder* are responsible for the enforcement of deportation procedures. Deportees are generally picked up by the relevant *Land* police authorities and taken to the airport. The National Agency received reports of inconsistent approaches in this regard.

During the deportation procedure on 29 May, the National Agency observed a family being picked up in the early morning in Bamberg and being taken to Frankfurt am Main Airport. The pick-up began at 5:30 a.m. The *Land* police officers were accompanied by an interpreter who explained the procedure to the family and informed them of their right to contact legal counsel or relatives. The family was given sufficient time to pack their luggage. Food and drinks were also available to them during the journey to the airport. However, when subsequently questioned at the airport, most of the deportees stated that they were not informed of their rights on the night of their pick-up, and that they received neither drinks nor food despite lengthy travel times in some cases.

From the airport onwards, the Federal Police generally takes control of the deportation procedure until the individuals are handed over in the target country.

If a deportation measure fails, the affected persons are required to return to their assigned place of residence. The visiting delegation was informed that there was no standardised procedure for this in the Federal *Länder*. In some cases, the *Land* Police would wait until the flight had departed so that, in the event of a failed deportation, they could return the affected person. This was the case for Hamburg *Land* Police, for example. In other cases, however, the *Land* Police would refuse to carry out such returns, citing issues relating to insurance and working hours. In such cases, the deportees have to return to their assigned place of residence independently and at their own expense. However, this is not possible if the affected persons have no financial resources. In the view of the National Agency, a uniform regulation should be adopted to stipulate that deportees must be returned to their previous accommodation after a failed deportation.

1.1 – POSITIVE EXAMPLES

The National Agency highlighted several positive examples during its visits.

For example, deportations at Leipzig/Halle Airport were carried out at a separate terminal. As a result, the Federal Police were able to adapt this area to the specific requirements associated with this measure. For instance, a play area was set up and two televisions were installed in order to keep the children entertained and occupied. There was also an outdoor area in front of the terminal which the deportees could enter and where smoking was permitted.

1.2 – FINDINGS AND RECOMMENDATIONS

Recommendations on the following main topics were submitted to the executive authorities:

1.2.1 – Deportation monitoring

The presence of deportation monitoring centres at airports and their regular exchange with authorities and non-state actors help to prevent or at least address misconduct during deportation operations. Deportation monitoring centres exist at the airports in Berlin, Düsseldorf, Frankfurt am Main and Hamburg. At Leipzig/Halle airport, the National Agency observed that only the airport's spiritual advisor – who is unable to provide first aid and who does not report on her findings – was present during deportation operations.

Deportation monitoring centres should be set up at all airports where deportations take place[48]. A dialogue should then be maintained between these centres and the competent authorities.

1.2.2 – Respect for the best interests of children

The deportees involved in one operation at Frankfurt Airport were predominantly families with children who had to wait several hours at the airport for their departure. There were no facilities to keep the children occupied. In response to a query from the visiting delegation, it was stated that the deportation monitor from the *Diakonie* association had a small selection of toys which could be handed out upon request. The Federal Police does not have any toys. The reason given for this was that the gate is normally used for regular passenger check-in procedures, meaning that permanent play equipment could not be installed.

Article 3 para. 1 of the Convention on the Rights of the Child provides that, in all actions concerning children, the best interests of the child shall be a primary consideration. Facilities to keep minors occupied have a calming and de-escalating effect on both children and – indirectly – on their parents. This can help participants to perceive the deportation process as being more respectful. For this reason, suitable facilities to keep children occupied should be available at the airport.

1.2.3 – Strip-searches

During one deportation measure at Leipzig/Halle Airport, each deportee was subjected to a strip-search involving a visual inspection of their genital area. This was carried out by medical staff in the presence of police officers. The reason provided for this was the particularly high-risk situation. Officers stated that deportees with a North African background were unwilling to fly, and that there was a risk that these persons might be carrying instruments capable of inflicting self-harm.

However, when asked how many air escorts would accompany a deportee during the measure, the officers came to a different risk assessment. Willingness to fly was once again cited as the decisive factor here. For persons who were unwilling to fly, officers stated that three escorts were required; those who were willing to fly, however, would require only two. As a result of the risk assessment, over half of the deportees were found not to be unwilling to fly, and were therefore accompanied by only two officers. This corresponds with the National Agency's impressions during its observations. The majority of deportees accepted the measure and did not put up any resistance.

There was no record of the intensity of the searches, and no justification was provided for carrying out this measure.

This approach reinforced the National Agency's impression from the previous deportation measure between Leipzig/Halle and Enfidha in 2017, namely that strip-searches were carried out merely on the basis of the individual's nationality, which would represent a violation of deportees' right to equal treatment. Furthermore, the knowledge that the vast majority of affected persons have already committed criminal offences is not a legitimate reason to routinely interfere with their privacy without considering each individual case.

Strip-searches involving a visual inspection of the prisoner's genital area represent a severe interference with the prisoner's general right of personality.[49] It should therefore be decided on a case-by-case basis whether there are in fact indications of a danger to public security and order that would justify a strip-search. Any such measures must adhere to the principle of proportionality.[50]

1.2.4 – Luggage

The National Agency observed that a person who was not at home at the time of collection was taken directly to the airport by the Hesse *Land* Police so that she could be deported. She was not given the opportunity to pack.

[48] Article 8 para. 6 of Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008

[49] Federal Constitutional Court, order of 05/03/2015, file no.: 2 BvR 746/13, margin no. 33

[50] Cologne Administrative Court, 25/11/2015, file no. 20 K 2624/14, juris margin no. 115 et seqq.

To ensure a dignified return, the person concerned should at least be given the opportunity to pack whatever personal belongings they need.[51] Deportation procedures should not lead to the person concerned losing their personal belongings. Contrary to the information provided by many authorities, it is not always possible for relatives to send personal belongings at a later date.

1.2.5 – Cash lump sum

The payment of a lump sum in cash is the responsibility of the respective foreigner authority of the *Länder*, and was not handled consistently. As a rule, the *Land* Saxony did not pay a lump sum to persons with no financial means unless this was requested by the deportees themselves. As barely any of the deportees were aware of this possibility, the system could end up being handled arbitrarily. At certain airports, the deportation monitoring centre voluntarily provided cash lump sums to persons being deported. This, however, was not reimbursed to the monitoring centre.

In the National Agency's view, nobody should be deported without financial means of their own. All deportees must have sufficient financial means to pay for the journey from the airport to the final destination, as well as for meals needed during this journey. Many Federal *Länder* have already adopted appropriate regulations as a result.[52]

1.2.6 – Information on the deportation procedure

Based on the National Agency's observations, deportees did not receive comprehensive written information regarding their rights and the deportation schedule. However, such information could help to reduce the stress experienced and the potential for resistance amongst deportees.[53]

At the time of collection, persons being deported should be provided with information on the deportation procedure. This should be done immediately, comprehensively, in writing, and in a language they understand well. The information sheet should include the following details:

- The schedule of the deportation including flight times
- Information on luggage
- Rights during the deportation procedure

1.2.7 – Unlawful deprivation of liberty

At Tegel airport, deportees who are not escorted during the deportation procedure on account of their risk assessment are locked up in one of the three larger custody cells while they wait for their flight. This can take several hours. In response to a query from the visiting delegation, the officers were unable to cite a legal basis for locking up the deportees. In their view, locking up the deportees did not constitute a deprivation of liberty because it was deemed necessary in order to carry out the deportation measure and therefore fell within the framework of the overall procedure.

From a legal perspective, this view is inconsistent with the past decisions of Germany's highest courts.[54] While both the collection and the waiting period at the airport (e.g. at the gate) are considered part of the deportation procedure, any additional confinement of the deportees is not.[55] This represents a deprivation of liberty which requires a basis in substantive law.[56] Section 39 (1) no. 3 of the Act on the Federal Police does not constitute a suitable basis, as the requirements stipulated therein would not be met in the present case. For instance, locking the door of the custody cell is not absolutely necessary. As the visiting delegation was

[51] Council of Europe, Twenty Guidelines on Forced Return, September 2005, Guideline no. 15, p. 44, URL: https://www.unhcr.org/4d948a7d9.pdf (retrieved on 07/03/2019)
[52] These are Brandenburg, Baden-Württemberg, Bremen, Lower Saxony, North Rhine-Westphalia and Thuringia
[53] CPT/Inf (2003), margin no. 41; CPT/Inf (2016) 35, margin no. 17; Council of Europe, Twenty Guidelines on Forced Return, September 2005, Guideline no. 4, p. 18, URL: https://www.unhcr.org/4d948a7d9.pdf (retrieved on 07/03/2019)
[54] Federal Constitutional Court, order of 15/05/2002, file no.: 2 BvR 2292/00; Federal Administrative Court, judgment of 23/06/1981, file no: 1 C 78.77
[55] Federal Constitutional Court, order of 15/05/2002, file no.: 2 BvR 2292/00, juris margin no. 28; Federal Administrative Court, judgment of 23/06/1981, file no: 1 C 78.77, juris margin no. 11
[56] Federal Constitutional Court Decisions 2, 118, 119; 29, 183, 195

informed at the police station, the only reason why deportees are locked up is because there is an insufficient number of staff available to supervise them.

In cases involving a deprivation of liberty, a judicial order is required pursuant to Article 104 (2) of the German Basic Law. According to information provided by the station, judicial orders were not obtained for the deprivations of liberty that had taken place. Thus, the practice in question was an unlawful deprivation of liberty that must be remedied as a matter of urgency.

The National Agency was informed of a similar approach at Frankfurt Airport. Here, a deportee reported that on the morning of his scheduled deportation – which did not take place until late in the evening – he had been collected from his apartment by the Hesse *Land* Police and initially taken into the custody of the *Land* Police in Offenbach for a period of several hours. According to the Hesse Ministry for the Interior and Sport, a judicial order was not required for this measure.

1.2.8 – Mobile phones

During the deportation measure observed at Leipzig/Halle Airport, deportees' mobile phones were taken from them upon arrival at the airport and withheld until they arrived in their country of destination.

During a deportation flight departing from Munich airport last year, the National Agency observed that all deportees did not have to surrender their mobile phones for the duration of the flight until shortly before boarding. This meant that the deportees were able to independently contact their relatives or legal counsel while waiting at the gate. Police officers at Munich Airport emphasised that this approach served to de-escalate the situation and that there were no security concerns.

Mobile phones should only be confiscated during a deportation procedure if this is deemed necessary in substantiated individual cases.

2 – CUSTODY AWAITING DEPORTATION

In 2018, the National Agency visited the Hesse facility for custody awaiting deportation in Darmstadt; the detention centre for persons required to leave the country in Büren, North Rhine-Westphalia (UfA Büren); and the Frankfurt Airport branch of the Hesse reception centre for refugees (HEAE Frankfurt Airport) in Gießen. The latter two visits were follow-up visits.

2.1 – POSITIVE EXAMPLES

The National Agency highlighted several positive examples during its visits.

During its first visit to HEAE Frankfurt Airport, the National Agency recommended that medical staff carrying out initial medical examinations should be specifically trained to recognise trauma and mental illness. During the follow-up visit, the visiting delegation found that a doctor has now been permanently employed at the facility. According to the head of the facility, this doctor has extensive experience in dealing with refugees and trauma.

Staff at the facility for custody awaiting deportation in Darmstadt come from many different cultural backgrounds and speak a wide range of languages, which should make communication with the detainees considerably easier.

Detainees awaiting deportation in Darmstadt and at UfA Büren were permitted to use their private mobile phones in order to maintain contact with their relatives, provided that the phone's camera had been taped over.

At the facility in Büren, a foam chair was used in the specially secured cell. This meant that individuals being held there did not have to sit on the floor. The spacious outdoor area was also viewed positively. Furthermore, detainees awaiting deportation had access to the internet.

2.2 – FINDINGS AND RECOMMENDATIONS

The visited facilities were given recommendations on the following main topics:

2.2.1 – Deportation from prison

Some of the detainees awaiting deportation at UfA Büren had come directly from prison, as it had not been possible to organise their deportation on time. This prolonged the detainees' deprivation of liberty and thus subjected them to an unnecessary burden.

Where persons who are required to leave the country are currently serving a prison sentence, every effort should be made to ensure they are deported before the end of their sentence. At the very least, it should be ensured that the conditions for deportation are in place before they have fully served their prison sentence.

2.2.2 – Furnishings and design

Neither the cells in the Darmstadt facility for custody awaiting deportation nor those in the special security unit of UfA Büren had curtains on the windows or any other possibilities for darkening the room.

It must be possible to prevent people from seeing into the cells from the outside. Detainees awaiting deportation must also be able to personally adjust the level of light.

2.2.3 – Strip-searches

Upon admission to the Büren detention centre for persons required to leave the country (UfA Büren), all detainees awaiting deportation were subject to a body search during which they were required to fully undress.

According to the Federal Constitutional Court, strip-searches involving a visual inspection of the prisoner's genital area represent a severe interference with the

prisoner's general right of personality.[57] They must not be carried out in the absence of case-specific suspicions.[58] To satisfy this requirement, general strip-search orders must allow for exceptions if the principle of proportionality so demands. Staff must be made aware that in individual cases it may not be necessary for the prisoner to undress fully. It is also recommended that the search be conducted in a respectful procedure, for example involving two stages where half the body remains dressed in each stage.

2.2.4 – Protection of property

At the Frankfurt Airport branch of the Hesse reception centre for refugees (HEAE Frankfurt Airport), male detainees were held in multi-occupancy rooms. Each detainee was given one compartment in which to store their private property. Neither the room nor the storage compartments could be locked.

To ensure that their property cannot be accessed by third parties, all detainees should have the possibility of locking their own personal storage compartments.

2.2.5 – Use of pepper spray

While transporting two individuals to the specially secured cell, staff at the Darmstadt facility for custody awaiting deportation used pepper spray, which they carried with them at all times while in the facility.

Due to the significant health risks involved, the use of pepper spray in confined spaces is not a proportionate measure under any circumstances. It should therefore be avoided inside facilities for custody awaiting deportation.[59]

[57] Federal Constitutional Court, 05/03/2015, file no: 2 BvR 746/13, juris margin no. 33 – 35
[58] Federal Constitutional Court, 10/07/2013, file no: 2 BvR 2815/11, margin no. 16, with reference to ECHR, van der Ven v. the Netherlands, judgment of 4/2/2003, application no. 50901/99, margin no. 62
[59] ECHR, Tali v. Estonia, judgment of 13/02/2014, Application no. 66393/10, margin no. 78; CPT/Inf (2008) 33, margin no. 86

2.2.6 – Visibility of toilets

At the facility for custody awaiting deportation in Darmstadt and at UfA Büren, the specially secured cells containing no dangerous objects were subject to comprehensive CCTV monitoring which also covered the toilet area. At UfA Büren, this was also the case for cells under intensive observation. The monitors each displayed non-pixelated images of the toilet area, and surveillance was carried out by staff of both sexes. As a result, the privacy of the individuals detained there was not sufficiently protected

CCTV cameras must be fitted in such a way that the toilet area is either not visible on the monitor at all or, alternatively, is only shown in the form of pixelated images. If deemed necessary in individual cases, it may be possible to permit unrestricted monitoring of detainees held in specially secured cells due to an acute danger of self-harm or suicide. However, any such decision should be carefully considered, substantiated and documented. The person concerned must in all cases be informed of the fact that visual surveillance is in operation. If a toilet area is indeed covered by CCTV monitoring and is not pixelated, only persons of the same sex as the detainee should carry out the monitoring.

2.2.7 – Lack of a legal basis for solitary confinement

At the time of the visit to the Büren detention centre for persons required to leave the country (UfA Büren), several individuals were being held in solitary confinement in the special security unit, including two individuals classified as posing a threat to public safety (known as *Gefährder*).[60] These individuals were segregated from the other detainees awaiting deportation. A mere one hour of outdoor exercise was permitted each day. The conditions of detention

[60] The concept of *Gefährder* stems from a resolution passed in 2004 by the Working Group of the Heads of the *Land* Criminal Police Offices and of the Federal Criminal Police Office and, has since been further defined by resolutions of the Conference of German Interior Ministers. Pursuant thereto, a person is considered a *Gefährder* if "certain facts justify the assumption that they will commit politically motivated criminal offences of a serious nature, particularly those within the meaning of section 100a of the Code of Criminal Procedure"

were similar to those found in solitary confinement in prisons.

The legal bases cited by the head of the facility (namely section 5 (1) sentence 2 and section 23 of the North Rhine-Westphalia Act on the Execution of Detention Awaiting Deportation) were insufficient for the execution of solitary confinement. Solitary confinement neither represents a mere restriction of the freedom to move around, nor can it be classed as a simple relocation to another detention wing. Until such point as a relevant statutory provision is in force, solitary confinement must not be executed in detention facilities for persons required to leave the country.

2.2.8 – Physical restraint

At UfA Büren, a restraining bed had been set up in the entrance area of the specially secured cell. These beds can intimidate detainees awaiting deportation and should therefore not be stored in an immediately visible location.

2.2.9 – Provision of information and exercise of rights

Detainees at the Darmstadt facility for custody awaiting deportation stated that they were unable to obtain any basic information regarding the facility itself, their conditions of detention or their rights. The house rules, for example, did not contain any specific information on possible complaint channels, contact details of non-governmental organisations active in the field, or information regarding medical care.

At UfA Büren, there were doubts as to whether the detainees awaiting deportation had been sufficiently informed of the relevant procedures for exercising their rights, such as the dates on which they could receive legal advice. These concerns were particularly applicable in cases involving a language barrier. At HEAE Frankfurt Airport, the house rules were only available in Arabic, English, French and Tamil.

Detainees awaiting deportation must be given information on all relevant issues – particularly those relating to their rights – in a language they understand well. In case of communication difficulties, an interpreter must be called upon to assist. In addition, information regarding the rights of detainees awaiting deportation, as well as basic information regarding their conditions of detention, should also be included in the house rules. The house rules should be made available in the necessary languages and handed out as required upon admission.

2.2.10 – CCTV monitoring

As regards CCTV monitoring, several recommendations were submitted concerning the doctor's room, common rooms and corridors.

Doctor's room

In the doctor's room of the facility for custody awaiting deportation in Darmstadt, a video camera had been installed on the wall which, according to the head of the facility, could not be switched off. The images from this camera are displayed on a monitor in the main office.

CCTV monitoring of medical treatment rooms constitutes a serious interference with the right of personality of persons concerned, and can also result in a breach of privacy (e.g. if the individual concerned removes their clothes). In the view of the National Agency, the indiscriminate and uninterrupted surveillance observed in the present case is unlawful and should be terminated immediately. Potential security risks should be handled in other ways.

Common rooms and corridors

At the facility for custody awaiting deportation in Darmstadt and at the Frankfurt Airport branch of the Hesse reception centre for refugees (HEAE Frankfurt Airport), the areas covered by CCTV monitoring included the common rooms and corridors. There was no light on the cameras to indicate to the persons concerned whether or not they were running. At HEAE Frankfurt Airport, the recordings were saved and then deleted after three days.

Following an enquiry by the National Agency, it was stated that the CCTV monitoring at HEAE Frankfurt Airport was carried out to protect public safety and on the basis of provisions from the Hesse Data Protection and Freedom of Information Act. However, it was still unclear which specific provision served as the legal basis for CCTV monitoring and storing data.

The CCTV monitoring of individuals constitutes an interference with their right to informational self-determination. CCTV monitoring should only be used in individual cases where it is absolutely necessary. The reasons for the use of CCTV monitoring should be documented. Furthermore, it must be possible for the person concerned to discern whether the camera is running.

2.2.11 – Psychological and psychiatric care

The facilities for custody awaiting deportation in Darmstadt and Büren did not provide any psychological or psychiatric care within the facility itself.

As detainees awaiting deportation have frequently undergone traumatic experiences while fleeing their country of origin and their deportation back there is accompanied by feelings of fear and anxiety, the need for psychological or psychiatric care in such facilities is generally high. It must be ensured that psychological or psychiatric care is provided where there is evidence of a psychological disorder.

2.2.12 – Dealing with *Gefährder*

At the time of the visit to UfA Büren, two individuals classed as *Gefährder* (i.e. persons posing a threat to public safety) were being held in solitary confinement. This involved restrictions in terms of visitation, correspondence, telephone calls and media usage, as well as the confiscation of property. As justification for the execution of solitary confinement, the staff merely cited the individuals' status as *Gefährder*.

In the documents sent to the National Agency, a risk of flight and *Gefährder* status were the reasons provided for these far-reaching measures. *Gefährder* status does not constitute a legally established and therefore suitable justification for the use of a special security measure, particularly solitary confinement. The necessity and intensity of any interference with basic rights should always be decided on a case-by-case basis and documented accordingly.

2.2.13 – Conditions of detention and security measures

According to the facility's management, extensive structural security measures were implemented at the Darmstadt facility for custody awaiting deportation when the facility opened. These included bars, fences, barbed wire and cameras. In some cases, the connecting pathways between individual buildings and the outdoor area in front of the common room were completely barred up on all sides and from above. As a result, these areas resembled a cage.

Detainees awaiting deportation were held in several units without common rooms. The only available common room was unlocked for only an hour each day. Outdoor exercise took place for an hour each day in a small, highly secure outdoor area. Apart from these two hours, the detainees were unable to leave their units. The only available facilities to keep them occupied were the TVs in the custody cells. From conversations with multiple detainees, it became clear just how difficult it was for them to wait around in their cells with nothing to do. In cases where custody pending deportation was executed on a wing of Frankfurt I Prison, the detainees awaiting deportation were permitted to leave their cells at any time of day. Furthermore, they had access to a wide range of facilities with which to keep themselves occupied.

Pursuant to section 2 of the Hesse Act on the Execution of Measures serving the Deprivation of Liberty under the Laws pertaining to Foreigners, detainees may only be subjected to such restrictions which serve the purpose of the measure involving deprivation of liberty or which prevent a concrete threat to security or order in a facility. The execution of custody pending deportation should, as a matter of principle, differ significantly from a prison sentence in terms of detention conditions, the restrictions of liberty that are specific to a prison sentence, and security measures.[61] The detention conditions in Darmstadt did not comply with this principle.

[61] CJEU, judgment of 17/07/2014, file no.: C-473/13 and C-514/13

Furthermore, it should be possible for detainees awaiting deportation to make meaningful use of their time. This can include access to common rooms, prayer rooms and kitchens where detainees can prepare their own meals.

The need for structural security measures should also be reconsidered in light of plans to expand the facility for custody awaiting deportation. It should be ensured that detention conditions differ more significantly from those found in prison, and that the restrictions imposed on detainees awaiting deportation are kept to an absolute minimum. Furthermore, the available premises should be made accessible for a longer period of time each day, and additional facilities should be made available to keep the detainees occupied.

2.2.14 – Proportionality of measures restricting fundamental rights

At the Büren detention centre for persons required to leave the country (UfA Büren), staff repeatedly informed the visiting delegation that the facility's demographic – and therefore its atmosphere – had changed significantly in recent years. They stated that the detainees awaiting deportation increasingly comprised criminal offenders and persons posing a threat to public safety (*Gefährder*). At the same time, the facility's management explained that the facility did not always receive comprehensive information concerning the background of the individuals being held there. For this reason, they added, it was often difficult to carry out a risk assessment.

With reference to the need to ensure security and order, stricter rules were imposed in the facility. For example, in contrast to the delegation's observations during its visit in 2013, the detainees awaiting deportation were not only locked up at night, but also during the day between the hours of 7 a.m. and 2 p.m. Furthermore, their movements during out-of-cell time were also restricted. For example, they were also locked in the common rooms during this time. Based on the documents sent to the National Agency, the number of special security measures was remarkably high compared to other facilities for custody awaiting deportation.

The positive atmosphere highlighted during the 2013 visit appeared to have given way to a fundamentally restrictive attitude during the follow-up visit. The National Agency sees a risk that fundamental rights may be violated without any factual basis for doing so. Furthermore, the conditions in which individuals awaiting deportation were held were generally similar to those found in the prison system.

Custody pending deportation should differ significantly from the execution of a prison sentence.[62] Any restrictive measures must be necessary and proportionate in each individual case. In addition, staff members' insecurities in dealing with the detainees ought to be taken seriously. The issue could be addressed, for example, by providing factual information and developing a clear strategy for individual risk assessment. This could help to raise staff confidence and prevent disproportionate restrictions to the rights of detainees awaiting deportation.

2.2.15 – Confidentiality of medical consultations

Where communication issues arise during the initial medical examination or during other doctor-patient consultations at the facility for custody awaiting deportation in Darmstadt, a member of staff or detainee is summoned to act as an interpreter. In addition, the head of the facility stated that the facility's social worker is always present during medical consultations. For reasons of confidentiality, as well as to ensure the correct translation of technical terms and subject matter, translations must always be performed by a professional interpreter. In addition, detainees awaiting deportation should have the possibility of engaging in medical consultations without the presence of a third party, provided there are no security concerns that would preclude this.

2.2.16 – Access to the law

Several of the detainees awaiting deportation in Darmstadt criticised the lack of possibilities for obtaining legal assistance. In response, the

[62] Opinion of Advocate General Yves Bot of 30/04/2014, file no: C-473/13, C-574/13 and C-474/13

facility's management pointed out that the facility was not legally obliged to offer free legal counselling.

In accordance with Article 19 (4) of the German Basic Law [*Grundgesetz*], any person has the right to effective recourse to the courts if his/her rights have been violated by a public authority. Even if the requirement to act as an intermediary is not explicitly prescribed in law (as is the case in North Rhine-Westphalia, for example[63]), the individuals concerned should at least be informed of the bodies which provide free legal advice (i.e. via an initial consultation with a lawyer) and how they can be contacted.

[63] Section 6 (3) of the North Rhine-Westphalia Act on the Execution of Detention Pending Deportation [*Gesetz über den Vollzug der Abschiebungshaft in Nordrhein-Westfalen*]

3 – FEDERAL AND *LAND* POLICE

In 2018, the National agency visited a total of eight police stations. These included three *Land* police stations in Lower Saxony, North Rhine-Westphalia and Thuringia, and five Federal police stations.

3.1 – POSITIVE EXAMPLES

The National Agency highlighted several positive examples during its visits.

As part of the scheduled renovations at Frankfurt am Main Federal Police District Office, CCTV monitoring is set to be installed in the custody cells. The cameras are to be activated only when the doors of the custody cells are opened. This type of system affords the greatest possible degree of privacy to the individual held in custody, and can also help to prevent abuse. In addition, level access to the custody suite is to be created, which will reduce the risk of injury when bringing highly agitated persons to their cells.

At Leipzig Federal Police District Office, the individual rooms for recording the personal details of individuals in custody, conducting searches, and carrying out other measures related to the custody process all had signs explaining, in various different languages, what would happen to the person concerned in each of the rooms. This means that, if communication difficulties arise, the person concerned is not left in the dark until an interpreter arrives.

3.2 – FINDINGS AND RECOMMENDATIONS

The visited facilities were given recommendations on the following main topics:

3.2.1 – Furnishing and fittings in custody cells

In both Federal and *Land* police stations, shortcomings were found with regard to the furnishings and fittings of custody cells. These included a lack of smoke detectors, non-adjustable lighting and no access to daylight. At one station, there were no regular checks to verify whether the emergency call system in the custody cells was working.

The conditions in police custody cells, including furnishings and fittings, must be respectful of the human dignity of detainees. Every custody cell should be equipped with a smoke detector, an emergency button, adjustable lighting, a non-flammable, washable mattress, a blanket and a pillow. Where a custody cell is only equipped with a low bed, it should have additional seating at standard height. Where the custody suite is located separately from the guard room or if it is in another part of the building, an intercom system is advisable. Checks should be carried out to ensure that the intercom and the emergency call system are working before each occupancy of a custody cell. Access to daylight is recommended for every custody cell, including those intended for short-term custody.

3.2.2 – Instruction of rights

One Federal police station kept written documentation on the instruction of individuals' rights under the Code of Criminal Procedure, but not for the instruction given in accordance with police law. At stations in North Rhine-Westphalia and Lower Saxony, instruction was not always provided in writing, and in some cases it was only provided when the detainee was released. In some cases, the instruction sheet stated that it was only possible to consult legal counsel under certain restrictions.

Regardless of the legal basis on which people are taken into custody, they must be immediately instructed about their rights in writing and in a language they understand. If a person was unable to be instructed about their rights when they were brought into custody, this must be done at the earliest possible time. It must be documented that instruction has been given.

3.2.3 – Strip-searches

In Federal and *Land* police stations, the National Agency found that individuals were subjected to strip-searches involving a visual

inspection of the genital area upon entering police custody. A case-by-case examination was generally not carried out.

Strip-searches constitute a serious interference with general rights of personality.[64] It should therefore be decided on a case-by-case basis whether there are indications of a danger to public security and order that would justify a strip-search. Any such measures must adhere to the principle of proportionality.[65] If a strip-search is carried out, the reasons for this should be documented in a clear and comprehensible manner. Furthermore, the search should be conducted as respectfully as possible, for example involving two stages where half the body remains dressed in each stage.

3.2.4 – Visibility of toilets

Custody cell doors at the *Land* police stations had peepholes through which the non-partitioned toilets were visible. Staff did not knock before looking through the peephole. Furthermore, the CCTV monitoring in some of the cells also covered the toilet area.

The privacy of individuals held in police custody must be protected. Monitoring an individual while they are using the toilet represents a considerable interference with their rights of personality. Staff members should indicate their presence in a suitable manner before looking through a peephole, especially if the toilet in a custody cell is not partitioned off. The person in the cell might be using the toilet and should be given the opportunity to indicate this.

CCTV cameras must be fitted in such a way that the toilet area is either not visible on the monitor at all or, alternatively, is only shown in the form of pixelated images. Unrestricted monitoring of the custody cell should only be permitted in carefully assessed, substantiated and clearly documented individual cases where there is an acute danger of self-harm or suicide. If a toilet area is indeed covered by CCTV monitoring and is not pixelated, only persons of the same sex as the detainee should carry out the monitoring.

3.2.5 – Shackles

At a *Land* police station in Thuringia, a “bodycuff” restraint system with metal handcuffs was used to shackle individuals in custody. The use of metal or plastic handcuffs can result in haematomas or compressed nerves.

In order to protect the right to physical integrity, any shackling in custody should be carried out using textile hand restraint belts.[66]

3.2.6 – Physical restraint

Land police stations in several Federal *Länder* still carry out measures of physical restraint.[67] At one station in North Rhine-Westphalia, individuals are bound to holes in the beds and on the wall using metal handcuffs. While continuous CCTV monitoring was in place, continuous personal supervision was not. From this position, the person under physical restraint was unable to reach the emergency call button.

Physical restraints should not be applied in police stations. According to the Federal Constitutional Court’s judgment of 24 July 2018, the application of physical restraint constitutes a serious interference with the right to freedom of the person (Article 2 (2) sentence 2 in conjunction with Article 104 of the Basic Law) and also poses a serious risk of injury.[68] For this reason, any restrictions of this right must be based on a formal law which is sufficiently precise and takes sufficient account of the principle of proportionality.[69] The measure must be ordered by a doctor and requires monitoring. Furthermore, it must be ensured that one-on-one supervision is provided by therapeutic personnel or care staff.[70] For any physical restraint applied for more than just a short period of time, a court decision is

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[64] Federal Constitutional Court, order of 05/03/2015, file no.: 2 BvR 746/13, margin no. 33

[65] Cologne Administrative Court, 25 November 2015, file no. 20 K 2624/14, juris margin no. 115 et seqq.

[66] An example of this can be seen in the model used by FRONTEX during deportation flights.

[67] See part III. 2.5 – “Physical restraint”

[68] Federal Constitutional Court, judgment of 24/07/2018, file no.: 2 BvR 309/15, 2 BvR 502/16, margin no. 83

[69] Ibid., margin no. 76 et seq.

[70] Ibid., margin no. 83

required.[71] The measure must be documented comprehensively. [72] The person concerned should be informed after the measure of the possibility to have a court review the permissibility of the restraint procedure. [73] Furthermore, it is the view of the National Agency that physical restraints should only be applied using a strap-based system.

The Federal police and the *Land* police stations of several Federal *Länder* no longer permit the application of physical restraint in police custody. At these stations, individuals who the police believe require physical restraint are transferred to psychiatric clinics. In its latest report on its visit to Germany, the CPT also calls upon the police authorities to put an end to the practice of physical restraint.[74]

3.2.7 – Custody documentation

Custody documentation at many Federal and *Land* police stations was inadequate. In one case, the custody records were not kept on site, but were rather kept exclusively at the superior agency. At several stations, there was incomplete documentation of the instruction on rights provided to persons taken into custody. In other cases, decisions to carry out a strip-search, as well as the justification for these decisions, were generally not documented. There were no regular checks of the custody record book by senior officers.

All detention-related information must be fully documented and available on site. Senior officers should check at regular intervals whether the documentation is complete. These checks should also be recorded.

3.2.8 – Size of custody cells

The custody suite of one police station in North Rhine-Westphalia included a multi-occupancy cell with a floor space of 18 square metres. The officers present did not know how many people were permitted to be held in this room.

[71] Ibid., margin no. 69
[72] Ibid., margin no. 84
[73] Ibid., margin no. 85
[74] CPT/Inf (2017) 13, margin no. 33

Even in cases where an individual is held in a multi-occupancy cell for just a short period of time, it must be ensured that they have enough space to sit down and walk around a little. According to the National Agency's standards, police custody cells must always have a floor space of at least 3.5 square metres for every person. Facing walls must be separated by a distance of at least two metres, and the ceiling must be considerably higher than two metres. This represents an absolute minimum requirement.

3.2.9 – CCTV monitoring

At police stations in North Rhine-Westphalia and Berlin, prison cells were frequently subject to continuous CCTV monitoring. There was nothing in the cells to indicate that monitoring was taking place, and it was not clear whether the camera was running.

CCTV monitoring should only be used in police stations in individual cases where it is imperative for the protection of the person concerned. The reasons for the use of CCTV monitoring should be documented. In addition, the person concerned must be informed that monitoring is taking place. The mere fact that the camera is visible is not sufficient. Furthermore, it should be possible for the person concerned to discern whether the camera is running.

3.2.10 – Multiple occupancy of custody cells with non-partitioned toilets

At a police station in North Rhine-Westphalia, the toilet in one multi-occupancy cell was not fully partitioned and did not have separate ventilation.

In order to ensure humane detention conditions, it is imperative that custody cells accommodating more than one person have a fully partitioned toilet with separate ventilation. Furthermore, according to past decisions of the Federal Constitutional Court, the placement of several prisoners in a single cell without a partitioned toilet and separate ventilation represents a violation of human dignity.[75]

[75] Federal Constitutional Court, order of 22/02/2011, file no.: 1 BvR 409/09, margin no. 30

3.2.11 – Respectful treatment

During its visit to a *Land* police station in North Rhine-Westphalia, the National Agency observed officers addressing individuals in custody using the informal "*du*" form in German.

Officers should speak to the individuals concerned using polite forms of address.

3.2.12 – Name badges

In several police stations, the officers working in the custody area did not wear name badges.

The National Agency recommends that name badges be worn on account of their preventive effect: by making it possible to identify officers, they can reduce the risk of abuse. Furthermore, a name badge allows the officers to be addressed personally by the person deprived of their liberty, which can have a positive effect on any interactions between them.

3.2.13 – Independent complaints and investigation office

At the Federal Police, citizen complaints are dealt with by the public relations department of the relevant Federal police regional office. A separate internal complaints office, which reports directly to the President of the Federal Police, is responsible for handling complaints submitted by police officers outside of the official channels.

Lower Saxony and Thuringia have police complaints offices within their interior ministries. In Thuringia, this office can be contacted by citizens. In Lower Saxony, the office can also be contacted by police officers. However, both bodies are only able to act as an intermediary in discussions.[76] The *Land* of North Rhine-Westphalia does not have an independent police complaints or investigation office.

A key element in preventing abuse by police officers is the detection, prosecution and punishment of police misconduct. Independent complaints and investigation offices should be perceived as unbiased points of contact by injured parties, witnesses and police officers. Furthermore, they should serve to increase confidence in the rule of law.

Allegations against police officers should therefore be investigated by independent bodies. According to the case-law of the European Court of Human Rights, independence is considered to exist if there are no institutional or hierarchical connections between the investigating officers and the accused officers, and if it is guaranteed that the investigations are fully independent in practice.[77]

In addition, independent complaints offices must be created which, in the event of allegations of police misconduct, enable the most amicable resolution for the parties concerned through channels other than investigation bodies e.g. via mediation proceedings. Furthermore, these independent complaints offices must have extensive powers to establish the facts – as is the case for the Citizens' Affairs Ombudsman of the *Land* of Schleswig-Holstein.[78]

3.2.14 – Confidentiality of conversations

At one Federal police station, all telephone calls by individuals in custody take place in the presence of police officers.

Confidential conversations between the accused party and his/her lawyer are essential in order to mount an effective defence and must therefore be allowed to take place. Confidentiality should also be assured for conversations with doctors or relatives.

3.2.15 – Weapons in custody

In Federal and *Land* police stations, some officers carried firearms and pepper spray while bringing individuals into custody or inspecting the custody cells.

Because of the risks involved, police officers should refrain from carrying weapons in the custody suite. This is stipulated by an internal Federal Police provision. Furthermore, due to

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[76] Töpfer, "*Unabhängige Polizeibeschwerdestellen*", Bürgerrechte & Polizei/CILIP 116, July 2018, p. 76

[77] Cf. inter alia ECHR, Kummer v. Czech Republic, judgment of 25/07/2013, Application no. 32133/11, margin no. 83; Eremiášova and Pechová v. Czech Republic, judgment of 16/02/2012, Application no. 23944/04, margin no. 135

[78] Section 4 (1) of the Act on the Citizens' Affairs Ombudsman and the Police Ombudsman [*Bürger- und Polizeibeauftragtengesetz*]

the significant health risks involved, the National Agency takes the view that the use of pepper spray in confined spaces is not a proportionate measure under any circumstances and should therefore be avoided. This is consistent with the view of the ECHR and the CPT.[79]

[79] ECHR, Tali v. Estonia, judgment of 13/02/2014, Application no. 66393/10, margin no. 78; CPT/Inf (2008) 33, margin no. 86

4 – JUVENILE PRISONS

The National Agency visited Arnstadt Juvenile Prison in 2018. This was a follow-up visit.

4.1 – POSITIVE EXAMPLES

The National Agency made the following positive observation during its visit:

The cells at Arnstadt Juvenile Prison are equipped with a telephone. This means that the juvenile prisoners can call their predetermined authorised contacts at any time.

4.2 – FINDINGS AND RECOMMENDATIONS

The visited facility was given recommendations on the following main topics:

4.2.1 – Strip-searches

According to officers, all prisoners were strip-searched without exception upon admission to the facility. According to the Federal Constitutional Court, strip-searches involving a visual inspection of the prisoner's genital area represent a severe interference with the prisoner's general right of personality.[80] They must not be carried out "routinely or independently of case-specific suspicions".[81] To satisfy this requirement, general strip-search orders must allow for exceptions if the principle of proportionality so demands.[82] Staff must be made aware that in individual cases it may not be necessary for the prisoner to undress fully. It is also recommended that the search be conducted in a respectful procedure, for example involving two stages where half the body remains dressed in each stage.

[80] Federal Constitutional Court, 05/03/2015, file no: 2 BvR 746/13, juris margin no. 33
[81] Federal Constitutional Court, 10/07/2013, file no: 2 BvR 2815/11, margin no. 16, with reference to ECHR, van der Ven v. the Netherlands, judgment of 04/02/2003, Application no. 50901/99, margin no. 62
[82] Federal Constitutional Court, judgment of 10/07/2013, file no.: 2 BvR 2815/11, margin no. 19

4.2.2 – Visibility of toilets

The specially secured room is equipped with a non-partitioned toilet and is fully visible – unbeknownst to the prisoner being held there – through a glass wall covered with reflective foil.

Providing persons deprived of their liberty with humane conditions of detention also requires that measures be taken to protect their privacy. This also applies when they are placed in a specially secured room. If the toilet in a cell is not partitioned off, it should not be fully visible at all times. The person in the cell must be given the opportunity to indicate that they are currently using the toilet. If deemed necessary in individual cases, it may be possible to permit unrestricted monitoring of detainees held in specially secured cells due to an acute danger of self-harm or suicide. However, any such decision should be carefully considered, substantiated and documented.

4.2.3 – Staff

During its visit, the delegation was informed of the tense staffing situation at the juvenile prison. Furthermore, it was stated that the promotion prospects of prison staff in the *Land* of Thuringia – which were regarded as being low – had a negative impact on job satisfaction.

Overworked and dissatisfied staff can have a negative impact on the treatment of persons deprived of their liberty. Staff shortages, for instance, can sometimes lead to a reduction in prisoners' exercise time. However, because physical exercise not only helps prisoners to stay healthy but also has the potential to improve their social conduct, it should be encouraged in all circumstances.[83] Moreover, a tense staffing situation can impact prison security.

4.2.4 – Respectful treatment

During its visit to the juvenile prison, the National Agency observed that staff did not

[83] Arloth/Krä, "*StVollzG-Kommentar*" [Commentary on the Prison Act], 4th Edition, section 67 StVollzG, margin no. 4

always knock before entering an occupied prison cell.

Detainees should be treated respectfully. This includes staff indicating their presence in a suitable manner before entering the prison cell.

5 – PRISONS

In 2018, the National agency visited Leipzig Prison and Hospital.

5.1 – POSITIVE EXAMPLES

The National Agency made the following positive observation during its visit:

Leipzig Prison was equipped with a suicide-prevention room for individuals who have expressed suicidal thoughts without exhibiting acute suicidal tendencies. The suicide prevention room focuses on providing treatment, and not only on preventing self-harm. The individuals occupying the room are provided with psychological care and are subject to continuous monitoring. If necessary, an examination can be carried out by a psychiatrist, who can then initiate a transfer to a psychiatric clinic. The room was pleasantly furnished, with bars covering only the lower part of the window. One side of the room was glazed and fitted with a window, which made it possible to contact staff in the adjacent room. Furthermore, there were additional blinds on the glazed side, which give the affected person the option of increasing their level of privacy.

5.2 – FINDINGS AND RECOMMENDATIONS

The visited facility was given recommendations on the following main topics:

5.2.1 – Medical care

Prisoners described the medical care provided at Leipzig Prison as inadequate, despite the fact that there is a hospital directly adjacent. There were also complaints of pain being treated inadequately or not being treated at all.

Prisoners are entitled to comprehensive and adequate medical care.[84] Facilities must ensure that this is provided.

[84] ECHR, Wenner v. Germany, judgment of 01/09/2016, Application no. 62303/13, margin no. 58

5.2.2 – Furnishings and design

In some cases, the walls of the prison cells were extremely dirty and the furniture was worn. The leisure areas were bare and were used for various other purposes – for example, as storage rooms. In addition, the prison cells did not have any curtains. The prisoners resorted to makeshift solutions in order to ensure privacy and to protect themselves from incoming light.

It should be possible to darken the cells and prevent people from seeing into them from the outside. At the same time, prisoners should be able to adjust the level of light themselves.

Prisons should have a pleasant design and should be renovated where necessary.

5.2.3 – Specially secured room

At Leipzig Prison, both the frequency and, in some cases, the duration of occupancy in the specially secured cell were very high compared to other prisons. Moreover, the specially secured cell did not have any seating.

When using specially secured cells, the principle of proportionality must be adhered to – both with regard to the decision to order the measure and the duration of its application. Where the period of detention lasts for several hours or days, it is inhumane to force prisoners to stand or sit on the floor. In a similar facility, the National Agency observed that covered foam dice were used as seating. This would be desirable for longer periods of detention.

5.2.4 – Drug tests

At Leipzig Prison, drug tests were carried out using urine samples. For urine samples provided by individuals who have received substitution treatment, an additional person is not immediately present. However, all other urine samples were subject to visual checks by general prison staff.

During its visits, the National Agency encountered various drug testing methods which minimised the degree of interference with

prisoners' privacy. These included the use of mouth swabs or a marker system. With these procedures, it is no longer necessary to observe the passing of the urine sample. In order to respect human dignity, at least one alternative method of drug testing should be available so that prisoners can choose the method they find to be the least intrusive.

5.2.5 – Physical restraint

The documentation on the application of physical restraint[85] at Leipzig Prison revealed that the frequency of physical restraint and the length of time for which it was applied were very high compared to other prisons and psychiatric clinics. Furthermore, the reasons for the doctor's decision to order physical restraint were not comprehensible in some cases. On the form for documenting the use of physical restraints, it was neither necessary to specify the less severe measures which had already been tried nor the reason why these measures were unsuccessful.

According to the Federal Constitutional Court's judgment of 24 July 2018, a physical restraint constitutes a serious interference with a person's freedom (Article 2 (2) sentence 2 in conjunction with Article 104 of the Basic Law) and presents a serious risk of injury.[86] Thus, any restrictions to this right may only take place on the basis of a formal law that is sufficiently precise and takes sufficient account of the principle of proportionality.[87] Physical restraint may only be applied as a measure of last resort.[88]

Every effort should be taken to reduce the frequency and duration of physical restraints. The physical restraint should be applied for the shortest possible period of time. On the documentation form for physical restraints, it should be stated which other measures have already been tried and why these failed.

For any physical restraint applied for more than just a short period of time, a court decision is required.[89] The person concerned should be informed after the measure of the possibility to have a court review the permissibility of the restraint procedure.[90] Furthermore, the measure should be professionally discussed with the person concerned afterwards, as this can lead to a reduction in the frequency and duration of measures involving deprivation of liberty.[91]

5.2.6 – Cell size

Over-occupancy was frequently observed at Leipzig Prison. Single-occupancy cells, for example, were often occupied by two people. Many of these cells had less than 10 square metres of floor space, excluding the sanitary area. Remand detainees were generally allocated three hours of out-of-cell time, while sentenced prisoners were permitted to leave their cells for four hours.

The combination of undersized cells and limited out-of-cell time leads to restrictive living conditions that interfere with the human dignity of the persons concerned. From the point of view of the National Agency, in order for detention conditions to be humane, a single-occupancy cell must have a floor space of at least six square metres, excluding the sanitary area. In cases where the sanitary area is not partitioned, one further square metre should be added for that area, giving a total floor space of at least seven square metres. For multiple-occupancy, a further four square metres of floor space must be added to this figure for each additional person, excluding the sanitary area.

5.2.7 – Staff

The National Agency was informed of a strained staffing situation at Leipzig Prison. According to prison staff, this meant that almost nobody attended further training courses. A number of interviewees also informed the National Agency that the staffing situation had resulted in an excessive workload and tensions among staff.

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[85] See part III. 2.5 – "Physical restraint".
[86] Federal Constitutional Court, judgment of 24 July 2018, file no.: 2 BvR 309/15, 2 BvR 502/16, margin no. 83
[87] Ibid., margin no. 76 et seq.
[88] Ibid., margin no. 80
[89] Ibid., margin no. 69
[90] Ibid., margin no. 85
[91] DGPPN [German Society for Psychiatry and Psychotherapy] (2018): *S3-Leitlinie "Verhinderung von Zwang: Prävention und Therapie aggressiven Verhaltens bei Erwachsenen."* URL: https://www.dgppn.de/_Resources/Persistent/154528053e2d1464d9788c0b2d298ee4a9d1cca3/S3%20LL%20Verhinderung%20von%20Zwang%20LANG%2BLITERATUR%20FINAL%2010.9.2018.pdf (last retrieved on 27/02/2019)

An excessive staff workload can have a negative impact on the treatment of persons deprived of their liberty. This was reflected in the short out-of-cell times and limited leisure opportunities, for example.

5.2.8 – Respectful treatment

During the visit to Leipzig Prison, it was found that staff did not always knock before entering an occupied prison cell.

Detainees should be treated respectfully. This includes staff indicating their presence in a suitable manner before entering the prison cell.

6 – PSYCHIATRIC CLINICS

In 2018, the National Agency visited a total of five psychiatric clinics in Bavaria, Hesse, Lower Saxony and Schleswig-Holstein. The visits comprised three forensic psychiatric clinics, one clinic for general psychiatry and one for child and youth psychiatry.

6.1 – POSITIVE EXAMPLES

The National Agency highlighted several positive examples during its visits.

All of the visited facilities offer internal and interdisciplinary training courses on the topics of de-escalation, non-violent communication and dealing with aggression. By dealing with these topics intensively and carrying out practical exercises on patient-friendly flight and defence techniques, it is possible to increase the confidence of staff when dealing with crisis situations. This can help to prevent assaults and reduce the application of physical restraints.

During an inspection of the files at a child and youth psychiatric clinic, the National Agency observed that the forms for ordering and documenting coercive measures included empty text boxes for describing the current situation, the patient's risk of self-harm or harm to others, and the measures that had already been taken to de-escalate the situation. The National Agency welcomes this approach, as it requires that an order to apply physical restraints must be carefully considered and justified, as opposed to simply ticking a box containing a pre-determined reason. In addition, a record is kept of when and by whom a reflective discussion was held with the person concerned.

On the wards of the forensic psychiatric clinics visited by the National Agency, patients were not locked up at night. This was viewed positively, as night lock-up would prevent continuous treatment and could interrupt the therapeutic process.[92] None of the facilities expressed any security concerns.

[92] Bulla/Hoffmann, "*Der Nachteinschluss – eine Methode des modernen Maßregelvollzugs? Forensische Psychiatrie und Psychotherapie*", Vol. 19, 2012, p. 204-216

In the visited child and youth psychiatric clinic, individual patients were assigned primary nurses and therapists, while therapeutic continuity was ensured even when patients were transferred to additional wards. This is viewed as sensible, as a change of therapist can potentially interrupt the treatment process and ultimately delay the therapy's success.

The National Agency also welcomed the spacious premises and ample outdoor area where patients are able to move around. Furthermore, the grounds of one forensic psychiatric clinic were secured via a hedge, which was visually inconspicuous. As the razor-wire security fence is hidden by bushes, the structural security measures were barely noticeable to patients.

On the wards of one general psychiatric clinic, there were many possibilities for submitting a complaint – including the option of complaining anonymously. The details of various contact persons were put up on display. In addition, a complaints box was available so that complaints could be submitted at any time – even on the closed ward.

6.2 – FINDINGS AND RECOMMENDATIONS

The visited facilities were given recommendations on the following main topics:

6.2.1 – Possibilities for complaint

On some wards, the National Agency repeatedly found that there was no way for patients to submit a complaint anonymously. At one facility there was no central record of complaints, which made it impossible to provide information on the number of complaints or their content.

Mentally ill patients on closed wards in particular may encounter huge difficulties when trying to contact a complaints body. A patient advocate can act as an intermediary in such situations. Publishing the contact details of patient advocates or an ombudsman can make it possible for patients to lodge a complaint. It could also be useful to offer regular consulting

hours at fixed times in order to make it easier for patients to initiate contact. The necessary contact details should be displayed in the wards so that they are clearly visible to patients. Furthermore, complaints should be recorded centrally and evaluated on a regular basis. This makes it possible to detect recurring issues and implement counter-measures if necessary.

6.2.2 – Outdoor exercise

In the child and youth psychiatric clinic visited by the National Agency, it was not guaranteed that patients could exercise outdoors every day. Even in prisons, it is a legal requirement that each person must have the opportunity to spend at least one hour per day outdoors and be able to exercise there. For children and juveniles, the ability to exercise outdoors should be guaranteed to an even greater extent. Outdoor exercise has unique health benefits that cannot be replicated by any other measure[93], and it is crucial to the development of young people. In similar facilities, outdoor exercise is made possible via a secure outdoor area.

6.2.3 – Deprivation of liberty

Segregation

In forensic psychiatric clinics, patients can be segregated from the wider community during crisis situations. According to one forensic psychiatric clinic, segregation periods lasted up to one year in some cases. Such lengthy periods of segregation represent a huge interference with an individual's rights of personality and are unacceptable from a human rights perspective. They should be limited to the shortest possible period of time. Segregation must be closely monitored in order to bring about a relaxation of the measure as soon as possible. Steps should therefore be taken to enable a reduction in the duration of segregation.

Insufficient social contact and constant isolation can have a significant negative impact on patients' mental health – particularly if they have no way of keeping themselves occupied.[94]

Physical restraint

At one general psychiatric clinic visited by the National Agency, it was observed that a patient had been physically restrained in a bed on the corridor of one of the wards. Without a partition wall to shield them from view, the patient was visible to passers-by.

In the view of the National Agency, accommodating patients under physical restraint in this way constitutes a violation of human dignity that must be avoided. Patients under physical restraint should be protected from view and, as a matter of principle, should be accommodated in a room.

In some cases, patients under physical restraint were only checked at specific intervals. This meant that the possibility of personal contact was not available at all times.

According to the Federal Constitutional Court's judgment of 24 July 2018, the application of physical restraint constitutes a serious interference with the right to freedom of the person (Article 2 (2) sentence 2 in conjunction with Article 104 of the Basic Law) and poses a serious risk of injury.[95] Thus, any restrictions to this right may only take place on the basis of a formal law that is sufficiently precise and takes sufficient account of the principle of proportionality.[96] The measure must be ordered by a doctor and requires monitoring. Furthermore, it must be ensured that one-on-one supervision is provided by therapeutic personnel or care staff.[97] For any physical restraint applied for more than just a short period of time, a court decision is required.[98] The measure is to be documented comprehensively.[99] The person concerned should be informed after the measure of the

[93] Arloth/Krä, "*StVollzG-Kommentar*" [Commentary on the Prison Act], 4th Edition, section 64 of the Prison Act, margin no. 1

[94] Weyers/Siegrist, "*Soziale Beziehungen und Gesundheit, Impulse für Gesundheitsförderung*", 4th. quarter, 2011, LVG für Gesundheit und Akademie für Sozialmedizin Niedersachsen e.V. (ed.), p. 2-3

[95] Federal Constitutional Court, judgment of 24/07/2018, file no.: 2 BvR 309/15, 2 BvR 502/16, margin no. 83

[96] Ibid., margin no. 76 et seq.

[97] Ibid., margin no. 83

[98] Ibid., margin no. 69

[99] Ibid., margin no. 84

possibility to have a court review the permissibility of the restraint procedure.[100] Furthermore, the measures should be discussed with the person concerned afterwards, as this can lead to a reduction in the frequency and duration of measures involving deprivation of liberty.[101]

In addition, the guidelines of the German Society for Psychiatry, Psychotherapy and Nervous Diseases [*Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e.V., DGPPN*] call for one-on-one supervision of patients under physical restraint, as well as the possibility for personal contact throughout the entire duration of the measure.[102]

The documents submitted by one forensic psychiatric clinic indicated that, in some cases, physical restraints were applied for a long period of time. In one instance, the duration of physical restraint was listed as 803 hours. It was not clear whether less severe measures had already been tried and, if so, why these were insufficient. There are serious doubts as to whether a physical restraint applied over such a long period of time can ever be proportionate. The causes of lengthy periods of physical restraint should be investigated, as it must be ensured that the application of physical restraint is limited to the shortest possible period of time. Furthermore, direct supervision is also required in order to identify the earliest possible point at which the application of physical restraint can be terminated. There should be documentation stating which less restrictive measures had already been tried and why these failed.

In one instance, the belt restraint system was not applied correctly. The bed did not have full-length side rails. In order to avoid accidents, it should be ensured that the manufacturer's safety instructions and warnings are taken into account when using a belt restraint system, and that the requirements of the Federal Institute for Drugs and Medical Devices (BfArM) are met.[103]

6.2.4 – Privacy

Occupancy of patient rooms

The rooms in one forensic psychiatric clinic were occupied by up to four patients. At another forensic psychiatric clinic, three individuals occupied a room with a floor space of around 17.6 square metres.

Confining three or more mentally ill patients to a single room can cause issues with the therapy process – even if the room is of sufficient size. This is because the lack of privacy can trigger aggressive behaviour and provoke incidents. For this reason, the protection of patients' privacy should be guaranteed. In the course of renovations or new construction projects, the rooms should be geared towards a lower number of patients.

Corridor beds

In some facilities, patients were placed in "corridor beds" when over-occupancy occurred.

When patients are placed in beds in the corridor of a ward, they no longer have the option of spending time alone. The privacy of the individuals concerned is severely compromised as a result. For this reason, facilities should refrain from accommodating patients in the corridor.

Where the use of corridor beds is unavoidable due to a large number of new arrivals, a partition wall must be used at the very least so that the bed is not directly visible to others. This type of accommodation should be limited to the shortest possible period of time.

Visibility of toilets

In the forensic psychiatric clinics, the observation rooms for crisis situations – e.g. for patients at acute risk of suicide – were all fitted

[100] Ibid., margin no. 85

[101] DGPPN [German Society for Psychiatry and Psychotherapy] (2018): "*S3-Leitlinie: Verhinderung von Zwang: Prävention und Therapie aggressiven Verhaltens bei Erwachsenen.*" URL: https://www.dgppn.de/_Resources/Persistent/154528053e2d1464d9788c0b2d298ee4a9d1cca3/S3%20LL%20Verhinderung%20von%20Zwang%20LANG%2BLITERATUR%20FINAL%2010.9.2018.pdf (last retrieved on 27/02/2019)

[102] Ibid.

[103] BfArM (2003): "*Informationen zu Fixierungssystemen*". URL: (retrieved on 07/03/2019); BfArm (2013): "*Information zu Sicherheitsrisiken von Patienten-Fixiersystemen*". URL: https://www.bfarm.de/SharedDocs/Downloads/DE/Medizinprodukte/risikoerfassung/empfehlungen/Patienten-Fixiersystem.pdf?__blob=publicationFile&v=2 (retrieved on 07/03/2019)

with a camera. The area captured by the camera also included the toilet area, which was then displayed on the surveillance monitor without pixelation. In one facility, the observation room was equipped with a viewing window through which the toilet area was also visible.

Privacy must also be guaranteed in psychiatric clinics. This also applies to persons who need to be placed in an observation room. Monitoring an individual while they use the toilet represents a serious interference with their general right of personality.[104] CCTV cameras must be fitted in such a way that the toilet area is either not visible on the monitor at all or, alternatively, is only shown in the form of pixelated images. If deemed necessary in individual cases, it may be possible to permit unrestricted monitoring of an observation room due to an acute danger of self-harm or suicide. However, any such decision should be carefully considered, substantiated and documented.

Viewing windows in observation rooms should have curtains fitted on the outside, for example, so that staff can close them when the patient wishes to use the toilet.

Respectful treatment

During a visit to one general psychiatric clinic, it was observed that staff did not always knock before entering a patient's room. At one forensic psychiatric clinic, the door to every room was fitted with a window which enabled staff to see into the patient's room.

Patients should be treated respectfully. For example, staff members should generally indicate their presence by knocking on the door before entering a room. As a rule, windows fitted on the doors of patients' rooms should be covered; they are to be used only when necessary and after knocking.

Confidentiality of conversations

In the general psychiatric clinic visited by the National Agency, the patients' telephone was located in the living area of the ward and was not partitioned. This made it almost impossible to make a private phone call.

Measures should be introduced to ensure that phone calls can be made confidentially. Examples from similar facilities include phone booths, cordless phones for patients to use in the patient room, or allowing patients to use their own mobile phone.

6.2.5 – Legality and documentation of medication

At one forensic psychiatric clinic, not all prescribed medication was discussed with the guardian responsible for health care. Instead, this matter was discussed only with the patient. However, the capacity of the person concerned to provide consent in the specific decision-making situation was neither established nor documented.

Effective consent is required for all medication. Declarations of consent to any changes in treatment or medication should therefore be documented. In the event that the responsible guardian is not consulted, the decision as to whether the person concerned was able to consent in the decision-making situation should also be documented.

[104] Dresden Higher Regional Court, order of 12/05/2004, file no.: 2 Ws 660/03, juris margin no. 17; Zweibrücken Higher Regional Court, order of 30/03/1994, file no.: 1 Ws 44/94, juris margin no. 5

7 – CUSTOMS

In 2018, the National Agency visited Frankfurt am Main Customs Investigation Office.

7.1 – POSITIVE EXAMPLES

The National Agency made the following positive observation during its visit:

At Frankfurt am Main Customs Investigation Office, a notice on the doors of the custody cells stated that the peephole was to be used only after knocking on the door. The National Agency welcomes this approach, as the privacy of individuals held in the custody of customs authorities must also be respected.

7.2 – FINDINGS AND RECOMMENDATIONS

The visited facility was given recommendations on the following main topics:

7.2.1 – Custody documentation

The custody record book at the Customs Investigation Office did not contain entries documenting the checks that had been carried out.

In order to protect the individuals in custody as well as the responsible members of staff, all custody-related information must be fully documented. Supervisors should verify at regular intervals whether custody records are being kept correctly. These checks should also be recorded.

7.2.2 – Smoke detectors

There were no smoke detectors in the custody cells of the Customs Investigation Office. Smoke detectors should be installed in order to protect individuals being held in custody.

VI
APPENDIX

1 – CHRONOLOGICAL LIST OF VISITS

Date	*Visit*
11/01/2018	Psychiatric hospital (forensic psychiatric clinic)
24/01/2018	Paderborn District Police Department
24-25/01/2018	Büren detention centre for persons required to leave the country
31/01/2018	Observation of a deportation procedure: Charter operation Leipzig/Halle – Enfidha (Tunisia)
01/02/2018	Leipzig Federal Police District Office
07/02/2018	Residential care and nursing home, Baden-Württemberg
07/03/2018	Arnstadt Juvenile Prison
14/03/2018	Berlin-Südkreuz Federal Police Station
16/03/2018	Residential care and nursing home, Bavaria
19/03/2018	Residential care and nursing home, Rhineland-Palatinate
20/03/2018	Residential care and nursing home, Hesse
13/04/2018	Residential care and nursing home, Hesse
18/04/2018	Meiningen Police Station
03/05/2018	Psychiatric hospital (forensic psychiatric clinic), Lower Saxony
03/05/2018	Residential care and nursing home, Brandenburg
17/05/2018	Residential care and nursing home, Baden-Württemberg
18/05/2018	Leipzig Prison and Hospital
29/05/2018	Observation of a deportation procedure from collection point in Bamberg to Frankfurt Airport, then onwards to Albania and Kosovo
29/05/2018	Hesse reception centre for refugees – Frankfurt am Main Airport branch
30/05/2018	Psychiatric hospital (forensic psychiatric clinic), Hesse
07/06/2018	Residential care and nursing home, Hesse
13/06/2018	Oranienburg Federal Police Station
13/06/2018	Wolfsburg Police Station
14/06/2018	Psychiatric hospital (general psychiatric clinic), Schleswig-Holstein
15/06/2018	Psychiatric hospital (child and youth psychiatric clinic), Schleswig-Holstein
21/06/2018	Residential care and nursing home, Berlin
22/06/2018	Residential care and nursing home, Berlin
27/06/2018	Residential care and nursing home, Brandenburg
28/06/2018	Residential care and nursing home, Brandenburg
09/07/2018	Residential care and nursing home, Hesse

10/07/2018	Residential care and nursing home, Thuringia
12/07/2018	Residential care and nursing home, Rhineland-Palatinate
25/07/2018	Residential care and nursing home, Mecklenburg-Western Pomerania
26/07/2018	Residential care and nursing home, Mecklenburg-Western Pomerania
07/08/2018	Residential care and nursing home, Saxony
08/08/2018	Residential care and nursing home, Saxony
13/08/2018	Residential care and nursing home, Thuringia
21/08/2018	Berlin-Tegel Airport Federal Police District Office, observation of a transfer, Federal Police Station Berlin-Zoologischer Garten
24/08/2018	Residential care and nursing home, Saarland
28/08/2018	Frankfurt am Main Federal Police District Office, Wiesbaden Federal Police Station
28/08/2018	Hesse facility for custody awaiting deportation, Darmstadt
12/09/2018	Residential care and nursing home, Lower Saxony
24/09/2018	Observation of a transfer, deportation measure from Frankfurt am Main to Islamabad (Pakistan)
27/09/2018	Residential care and nursing home, Hamburg
28/09/2018	Residential care and nursing home, Hamburg
01/10/2018	Residential care and nursing home, Saxony-Anhalt
02/10/2018	Residential care and nursing home, Saxony-Anhalt

2 – MEMBERS OF THE FEDERAL AGENCY

Name	*Official title*	*Since*	*Position*
Klaus Lange-Lehngut	**Ltd. Regierungsdirektor (retd)**	**12/2008**	**Director**
Ralph-Günther Adam	Ltd. Sozialdirektor (retd)	06/2013	Deputy Director

3 – MEMBERS OF THE JOINT COMMISSION

Name	*Official/professional title*	*Since*	*Position*
Rainer Dopp	**State Secretary (retd)**	**09/2012**	**Chair**
Petra Heß	Employee of Thuringia State Chancellery	09/2012	Member
Dr Helmut Roos	Ministerialdirigent (retd)	07/2013	Member
Michael Thewalt	Ltd. Regierungsdirektor (retd)	07/2013	Member
Dr Monika Deuerlein	Certified psychologist (Dipl.-Psy.)	01/2015	Member
Prof. Dirk Lorenzen	Psychological psychotherapist	01/2015	Member
Margret Suzuko Osterfeld	Psychiatrist, psychotherapist	01/2015	Member
Hartmut Seltmann	Senior Chief Superintendent (retd)	01/2015	Member

4 – SECRETARIAT STAFF

Name	*Professional title / position*
Christina Hof	Political scientist (M.A.), Head of Specialist Services
Jennifer Trunk	Fully-qualified lawyer (*Rechtsassessorin*), specialist in European law, Deputy Head of Specialist Services
Elisabeth Eckrich	Nursing educator (B.A), Research Associate
Fredericke Leuschner	Sociologist (M.A.), Academic Assistant
Barbara Pachmann	Certified medical educator (*Diplom-Medizinpädagogin*), Research Associate
Sofie Sonntag	Fully-qualified lawyer (*Rechtsassessorin*), Research Associate
Katja Simon	Public administration specialist (*Verwaltungsfachwirtin*), Administrative Department
Jill Waltrich	Management assistant in office communication, Secretariat

5 – ACTIVITIES IN THE PERIOD UNDER REVIEW

Date	*Location*	*Activity*
18 January 2018	Berlin	Expert discussion to prepare for the 9th meeting of the UN Open Ended Working Group on Ageing
29 January 2018	Berlin	Discussions with the German Association of Care for the Elderly and the Disabled [*Verband Deutscher Alten- und Behindertenhilfe e.V.*]
12-13 March 2018	Trier	NPM Conference of the National Agency and the Austrian Ombudsman Board: Monitoring homes for the elderly
15 March 2018	Munich	6th Symposium on the "Werdenfelser" approach: Reform of the approval requirement for measures involving deprivation of liberty for children
9-11 April 2018	Rehburg-Loccum	Conference at Evangelische Akademie Loccum: "Reducing coercive measures in psychiatric clinics, alternative approaches for everyday practice"
17-18 April 2018	Ljubljana	Meeting of NPMs for the 10-year anniversary of the Slovenian NPM: "NPM Impact Assessment"
7-8 May 2018	Frankfurt	Conference on the aims and needs of young people with regard to measures involving deprivation of liberty by child and youth welfare services
17 May 2018	Kiel	Event held by the Commissioner for Refugees, Asylum and Immigration Matters of the *Land* of Schleswig-Holstein: "The Oury Jalloh Case – What happened? What can we learn from it?"
24 May 2018	Berlin	Expert discussion to prepare for the 9th meeting of the UN Open Ended Working Group on Ageing
12 June 2018	Berlin	Reception for the publication of the 2017 report of the National Agency for the Prevention of Torture
7-8 July 2018	Münster	22nd Conference on Empirical Police Research: "Democracy and Human Rights – Challenges for Police Training"
13 July 2018	Munich	7th Symposium on the "Werdenfelser" approach: Challenging behaviour among adults as a challenge in elderly care, psychiatric clinics and facilities for the disabled

17 July 2018	Frankfurt (Oder)	Viadrina European University Summer School “The European System of Human Rights Protection”
10 October 2018	Berlin	Follow-up discussion on the 9th meeting of the UN Open Ended Working Group on Ageing
16-17 October 2018	Oranienburg	International conference held by Brandenburg Police University: “Fair Treatment of Persons in Police Custody”
23-24 October 2018	Vienna	Exchange of experiences between German-speaking NPMs
26-28 October 2018	Wiesbaden	Conference held by the Centre for Criminology (*Kriminologische Zentralstelle e. V.*): “Violence and force in an institutional context”
22 November 2018	Berlin	Exchange with the Federal Government's Care Representative, State Secretary Andreas Westerfellhaus
7-8 December 2018	Dresden	International conference held by TU Dresden: “We have Come a Long Way - The Universal Declaration of Human Rights at 70 - Normativity and Compliance”