Projekt Paulus

Systematic Failures of Public Authorities in Denmark

Documentary report on authorities' knowledge, positive obligations, failure to protect and accountability
Main period 2006 to 2025, with separate follow-up to 11 October 2026



Ole Bakkestrøm
Project Manager, Projekt Paulus

11 October 2026

Ex officio et ex conscientia.

English translation. Figures retain source notation: 1.000 = 1,000; 1,5 = 1.5.
Danish quotations are translated; source identifiers and URLs are unchanged.

1 Summary of the main conclusions

During the period 2006 to 2025, Denmark experienced massive and systematic failures of legal safeguards and protection in municipal child and family administration, social services and disability administration, employment-related case processing, psychiatric assessment and coercive measures, and police and supervisory oversight. The tax and immigration appeal processes also document extensive corrections to individuals' legal positions; the healthcare complaints system documents extensive criticism of healthcare professionals and treatment providers. The failures include inadequate grounds for decisions, failures to ensure participation and family contact, missing or delayed assistance, unlawful coercive interventions, inadequate protection and investigation, and a chain of oversight and accountability that has not ensured timely cessation and redress. In child welfare, the authorities' knowledge has been documented since 2006, and subsequent independent case samples document repeated breaches of the same key safeguards. In the other areas, the specific years and repetitions are set out in the documentation.

Aggregate record total – gross sum of selected oversight and correction records from 2006 to 2025: 202.870.

The review of appeals in municipal social services and employment matters alone comprises 134.436 amendments, annulments or remittals: 54.663 amended or annulled decision outcomes and 79.773 remittals. In addition, there are 6.824 negative outcomes relating to psychiatric interventions and partial decisions, 354 decisions criticising police conduct, 711 successful outcomes in complaints about police operational decisions, 15.474 healthcare complaint outcomes involving criticism, 36.012 tax appeal outcomes, 6.265 outcomes in which Udlændingenævnet amended, annulled or remitted decisions, and 2.794 Ombudsman records involving criticism, requests for action or recommendations. The figures make a persistent problem visible across hundreds of thousands of oversight records; repeated reviews of the same incident or individual may appear in several streams.
The aggregate record total is an overall measure of the volume of the selected oversight and corrective outcomes. Each category retains its specific evidential value: a remittal, a finding in favour, criticism and an unlawful coercive intervention are different outcomes. The total therefore does not count 202.870 different individuals or separately established violations of the Convention. The municipal series covers 19 reporting years; the transitional year 2013 is missing. The healthcare series also include private treatment and, in some of the historical years, Greenland and the Faroe Islands. Other gaps and changes in recording units are specified in the annual tables. International decisions, favourable asylum outcomes, recognised patient injuries and reviews of cases that were not appealed are shown separately. They have not been added to the aggregate record total.

The separate documentation concerning children is more direct about actual unlawful practice: five historical practice surveys record at least 361 case instances containing errors among 571 examined. The Child Welfare Case Barometers for 2020–2024 record 4.459 deficiencies concerning five central statutory requirements in 3.629 case instances examined. At least 1.446 case instances in these five samples have one of the measured deficiencies. The figures have their own denominators and must not be added together as unique children or added to the overturnings on appeal. The National Audit Office’s subsequent investigation finds at least one measured breach of law in 69 per cent of 3.148 first placement courses from 2022–2024. This shows that the problem continues in cases that have not been appealed and in the actual protection of children.

The verified international count comprises 24 distinct ECtHR proceedings with a finally established Convention violation among judgments delivered in 2006–2025, counted by final status as at 11. October 2026. It also comprises 57 favourable Views on the merits from UN treaty committees: 23 with an expressly established violation, including three with an additional forward-looking protective finding, and 34 with purely forward-looking or conditional protective findings. Added to this is a separately established Article 22 procedural violation in the F.K. case. The European decisions concern, among other things, the duration of proceedings and effective review, freedom of association and expression, discrimination and family reunification, deprivation of liberty and psychiatric coercion, expulsion and children’s private life, investigation of rape complaints, and the use of force and protection of life in prisons.

The UN findings concern, in particular, protection against torture and abuse upon removal, protection of children, discrimination, family life and psychiatric coercion. These are separate categories of decisions and findings; no consolidated count of unique victims is derived from them.

The national conclusion rests on several different lines of evidence: historical practice studies; newer studies of unappealed cases; specific individual histories; the supervisory authority’s own activities and responses; known international warnings; and documented exemptions from responsibility or delays. The same problem appearing in several reports is counted as a knowledge and follow-up chain when the reports draw on the same material. It is counted as independent recurrence when new case samples or new events are actually examined. This distinction strengthens the systemic criticism: it becomes verifiable and does not depend on inflated figures.

1.1 The authorities have known of the problems for a long time

Studies of placements in care published in 2006, 2008, 2009 and 2011 documented shortcomings in consent, child welfare assessments, action plans, involvement and return home. Rigsrevisionen's report of April 2026 still found at least one of the measured breaches of law in 69 percent of the first placement episodes of 3.148 selected children from 2022-2024. Statsrevisorerne highlighted the authorities' knowledge over at least twenty years. Institutional responsibility therefore cannot be assessed on the premise that these problems have only just been discovered. The central question is why known safeguards still failed in cases concerning further children.

A separate historical example goes further back. In 2010, the Ombudsman found that central health authorities had, for twenty years, accepted an unlawful practice which, in the circumstances described, exempted hospital doctors from liability for failure to keep medical records. This is concrete evidence of institutionally accepted exemption from liability. It is not evidence that the same practice continued unchanged after 2010; subsequent correction and reconsideration must be examined separately.

1.2 Many improvements have not been documented as improvements for the citizen

New guidance, more staff, a course, an action plan or completed supervision documents an activity. None of these circumstances alone documents lawful practice, assistance delivered or the end of a loss of rights. The Langeland course of events demonstrates the difference concretely: in May 2026, the Ministry required a fresh examination of legality, reopening and sanctions after the Appeals Board had previously declined further supervision. Municipal staffing increases and organisational changes had not provided a sufficient basis for concluding that the administration was lawful.

The term pseudo-improvement is therefore used for a claimed improvement presented as evidence that a problem is solved, although its effect on citizens is not documented or later review shows continuing errors on the same point. Lack of effect measurement does not alone prove that every activity was ineffective. It proves that the authority lacks a basis for declaring the problem solved. Where serious findings recur after many years of initiatives, the criticism becomes inadequate and inadequately verified remedial action. An allegation of deliberate cosmetic action requires its own evidence.

1.3 Control can close its case while the citizen's loss continues

Rigsrevisionen’s oversight investigation covered 1.669 closed cases from 2018-2024: 1.114 were rejected and 555 examined further. The four examined powers involving annulment, coercive fines, damages proceedings and penalties were not used in this material. The figure of 67 percent rejected concerns oversight cases. It must not be rewritten as rejection of 67 percent of citizens’ ordinary appeals. The criticism concerns the oversight body’s documented weaknesses in enforcement and follow-up within the investigation’s scope.

Remittal for reconsideration is likewise not a child’s return home, assistance delivered or payment of an awarded amount. Oversight systems that primarily count administrative endpoints can conceal that part of

the loss of rights occurring before the complaint or after the finding in the party's favour. The authorities must therefore document what actually happened to the affected citizen, and when.

1.4 Protection from accountability and de facto impunity are a central problem

The material does not document general statutory immunity for all public employees. It documents specific exemptions from liability, limits on personal financial liability, weak responses and instances in which the authorities' own delays have weakened or precluded disciplinary action. The unlawful record-keeping practice is the clearest example of an institutionally accepted exemption. The police disciplinary summaries and the Tibet case show other mechanisms that must be examined according to their specific scope.

When an employee or manager can continue to exercise the same powers of intervention after documented serious breaches of duty, and no one has examined or justified the risk of recurrence, the problem extends beyond inadequate punishment. It represents a possible further failure to protect the next citizens affected. The material supports a demand to investigate this mechanism. It supports an individual allegation of serial violations when the same actor, several specific incidents, knowledge and continued service are documented. Such links to individuals have not been published as a consolidated national register.

1.5 Management pressure must be traced to the person issuing or maintaining the order

The Danish Association of Social Workers' survey of September 2024 recorded that 21 percent of 519 respondents had encountered unlawful decisions at their workplace. Among the 109 respondents who answered yes, 77,1 percent cited finances and 53,2 percent the wishes of senior management as reasons; multiple answers were possible. These are professional respondents' assessments, rather than 109 court-established cases or a measurement of all Danish social workers. This is a specific and significant lead concerning governance and managerial responsibility.

The combination of perceived management pressure and limited visible personal accountability can make compliance with management the most immediate, tangible advantage and resistance a perceived employment risk. This incentive analysis cannot be converted into a proven national probability of dismissal or punishment. It must be tested against instructions, personnel files, warnings, professional objections and managers' actual responses. The report demands that responsibility be traced upwards and that documented lawful resistance be protected; accountability must not stop with the frontline employee.

The mechanism of management and obedience also has an official legal basis: a duty to follow certain orders that later prove unlawful can coexist with an absence of individual liability for the person carrying them out. The authority's liability remains. Specific adverse responses to lawful statements are documented in Ombudsman cases from 2019 and in a sequence of events from 2025 assessed in 2026.

1.6 The State has a duty to protect even when individual criminal culpability has not been established

Depending on the relevant right, positive obligations include prevention, specific protection, effective investigation, accessible review and redress. They have different conditions under ECHR Articles 2, 3, 8 and 13. The absence of an individual conviction does not extinguish these duties. In 2023, the UN Committee against Torture criticised, among other things, the excessively narrow focus on individual criminal guilt in certain police complaint investigations. Serious incidents must be clarified even when precise individual responsibility cannot yet be established.

Failure to protect is used here to describe the authorities' failure to secure the specific protection required by binding rights and national duties. The expression is not an independent Danish criminal provision. The analysis rests on the individual rules of protection and State responsibility. It does not rest on the international political R2P framework. The strongest documented case must be capable of being pursued without transferring it into a different set of rules with different conditions.

1.7 Time can both worsen harm and protect those responsible

Delayed assistance, limited family contact, prolonged uncertainty and late review are different consequences that may reinforce one another. At the same time, delay may weaken evidence, trigger limitation periods or mitigate a response against the responsible person. The material documents specific disciplinary processes in which almost four years of case processing affected the response, and in which a late recommendation meant that disciplinary proceedings were not opened. The state must examine the original act and its own delay in accountability as two matters.

An increased administrative time target does not improve the citizen’s waiting time. The Appeals Board’s target changed from 13 to 30 weeks, while the time in 2025 was around 35 weeks. Closure of oversight based on the new target documents neither fulfilment of the old target nor an effective remedy in the individual case.

1.8 Creation of evidence and narratives by authorities requires independent scrutiny

Records, professional assessments and judicial reasoning do not gain greater evidential weight merely through repetition. The material contains specific examples of incorrect source attribution in police reports, deficient or misleading records and later investigations that changed earlier official explanations. Ronnie Kristensen's articles and Marie Broberg's book describe an experienced mechanism in which the citizen's objections are themselves reinterpreted as problems with the citizen. The legal examination must show the original statement, its alteration, the omitted documentation and significance for the decision.

The DUBU case in Langeland documents a risk of inaccurate activity records. The Ombudsman's announcement of March 2026 also reports municipal compensating measures and contact with KOMBIT. This does not prove intentional falsification of all records. The demand is to check corrected and still incorrect information and the decisions in which it was used.

1.9 The damage to the citizen cannot be reduced to an administrative error rate

In children’s services, failures of safeguards affect the right to be heard, family contact and the factual basis for intervention. In disability cases, delayed support can transfer necessary caring tasks to the family and restrict independence. In illness and deprivation of liberty, postponed protection can have consequences that a late letter cannot remedy. The articles on resonance and loss of effectiveness contribute a useful question: can documented objections actually change the decision and the assistance? They are analytical models, rather than clinical diagnoses or independent evidence of criminal intent.

1.10 Overall requirements of the report

Denmark must be able to show a coherent chain from the first known error to actual cessation, specific redress and verified safeguards against recurrence. Individuals’ rights must not depend on their ability to pursue repeated appeals, pay for private assistance or withstand years of struggle over their cases. Already documented errors must be remedied while further accountability tracks are investigated. Gaps in documentation must not be used as grounds to postpone protection that already has a sufficient basis.

The report demands independent re-examination of affected cases, preservation of original material, timely assessment of responsibility, separate scrutiny of management and supervision, specific assessment of continued access to powers of intervention, actual redress and public verification of effectiveness. Documented errors, substantiated suspicions and missing evidence are kept in separate lists. This does not exonerate any institution. It shows precisely which claims can be pursued now and which specific records can complete the evidential basis for the remaining claims.

1.11 Main conclusion on human rights and international law

The report's overall conclusion is that child and family administration, social and disability administration, employment case processing, psychiatric assessment and coercion, and police and supervisory oversight have failed massively and systematically to uphold central protective safeguards. Tax and immigration oversight also documents extensive corrections of individuals' original legal position; the healthcare complaints system documents extensive critical findings. In the children's field, recurrence is documented throughout the twenty-year period examined. The legal accusation concerns inadequate protection of ECHR rights and the specific protective duties under the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities and the ICCPR. In cases of serious treatment and deprivation of liberty, the Convention against Torture is also relevant. Chapter 6 and the legal evidence chains in chapters 7-10 connect the provisions to each field. This conclusion is the report's document-based legal analysis; the specific national breaches of law and Convention violations already adjudicated are identified separately.

Aggerholm v. Denmark, 45439/18, judgment of 15. September 2020, provides a direct Danish example: the ECtHR found a violation of ECHR Article 3 in the continued use of belt restraint. There is therefore an adjudicated Danish Convention violation in a field in which later complaint statistics continue to find unlawful duration. The later decisions have their own evidential and legal bases; they require examination of the learning and protection that the judgment was intended to bring about.

Responsibility under international law rests with Denmark as a State. Municipal self-government, regional organisation, internal allocation of responsibility and an employee's limited personal liability cannot extinguish the treaty obligation the State must fulfil. The relevant attribution rules and requirements for cessation, reparation and prevention of recurrence are examined in chapters 6.19-6.21. Criticism of specific oversight authorities' omissions is therefore also criticism of the State's protective structure.

1.12 Protection from accountability can prolong the State's own failure to protect

When an authority knows that serious breaches of duty recur, it must investigate both the individual action and the continuing risk. The Danish evidence specifically shows unlawful exemption from responsibility, delays that weaken the response and documented problems with management control and protection of lawful criticism. General Comment No. 31 from 2004 and Gäfgen v. Germany from 2010 provide the international basis for examining accountability and continued performance of duties in cases of serious violations. National person linkage is missing for an overall allegation concerning named serial violators; in the documented individual chains, examination of responsibility and risk can already be demanded.

Responsibility to protect is reviewed through UN paragraphs 138-139 from 2005 and the three-part framework from 2009. The report's failure to protect conclusion rests directly on human rights' positive obligations. Any classification as crimes against humanity requires the separate evidential chain in chapter 6.23-6.24. The precise international-law structure strengthens the claims that the available material can support and identifies the further evidence required for international personal criminal responsibility.

Contents

The summary comes first. Documentation, accountability, demands and analytical appendices follow. Literature and full sources are collected at the end.

1 Summary of the main conclusions 2

2 Basis of evidence and verification of evidence 8

3 Denmark’s documented knowledge and the failure to resolve the problems 37

4 Improvements must be tested on their actual effect 40

5 Immunity, liability exemption and risk retention 42

6 Positive obligations, human rights and responsibility under international law 46

7 Children and families: safeguards that fail through new generations of cases 56

8 Police and accountability checks: from lack of protection to weakened response 62

9 Health and psychiatry: time-dependent rights, incorrect measurements and shared responsibilities 65

10 Social services, disability and employment: the basis for assistance and losses transferred to the family 70

11 Other areas of authority and control of the State's own explanations 73

12 The contribution of articles and books: human impact translated into documentable conditions 80

13 Mechanisms that can make a known failure persistent 86

14 Demands for cessation, redress, effective supervision and accountability 89

15 The overall conclusion of liability and the strongest pleas in law 92

16 Documented errors and precise evidence status 96

17 Suspicions and hypotheses requiring further evidence 98

18 Missing documents and necessary investigative measures 99

19 Source and evidence chains for the decisive claims 102

20 Annex A – locator index for Magtmisbrug & Forvaltningskultur 105

21 Annex B – location index for De Retsløse 121

22 Annex C – verification form for each allegation of responsibility 122

23 Literature - books and articles 123

24 Sources - public originals and precise locators 125

2 Basis of evidence and verification of evidence

2.1 What is assembled

The report brings together public oversight reports, practice surveys, legislative texts, judgments, international rights documents and published books and articles. Its main claims are explained in the report. The short clickable reference numbers lead to the literature and source sections at the end, which bring together publisher, title, year, relevant passage and public link to the original. Human accounts and theories are assigned their precise evidentiary function.

References to a PDF identify the document's printed pages where that is how the original numbers them; where a click opens a physical PDF page, that page is identified separately. A digital reader may ignore a page fragment; the visible page number or paragraph in the reference still identifies the relevant passage. The statutory version and judgment paragraphs are expressly identified. The report does not require access to a private file archive.

2.2 Four different evidence functions

Primary oversight and legal sources document the specific decision, delimited review finding, authority's statement or relevant rule. They are tested against their methodology and the original records they reproduce. Published personal accounts document what their narrators describe and identify original case records to be produced. Theoretical and essayistic articles contribute questions and explanatory models; their general psychological or biological statements are not in themselves clinical evidence of causation in an individual case.

Repeating the same information in several analyses does not produce several independent pieces of evidence. A later summary must be checked against the original text. The report’s factual allegations therefore rest on the named review findings, judgments and identified original records. A methodological description or quality label provides no separate legal evidentiary value.

2.3 Systematic means documented recurrence and failure in the scrutiny chain

The report's conclusion of systematic failure rests on duration, repeated new findings, known duties, relevant authorities' knowledge of the problem, insufficient follow-up and specific losses. The expression does not claim that every administrative decision is unlawful or all employees share a hidden purpose. Where instructions, management or intent are documented, they are addressed directly. Where only the pattern is documented, the criticism is pursued as an institutional pattern and a specific demand for investigation.

A single serious error may give rise to a claim without being systematic. Recurrence after knowledge can document a heightened oversight problem even without a national victim total. Institutional knowledge differs from an individual manager's documented receipt. For personal responsibility, date, document, recipient, competence and realistic opportunity to act are connected to the specific continuing act or omission.

2.4 The mandatory chain for each criticism

Each decisive criticism follows this order:conclusion; the authority’s specific statement; original evidence; discrepancy or deficiency; relevant rule; action or omission; legal departure; significance for the outcome; responsibility; specific legal consequence or demand. The dossiers below use this structure. An undocumented link is recorded where it is missing. It does not change other links that are documented.

The origin of the claim and the source chain are checked separately. A summary must be compared with the document it purportedly reproduces. Language such as professional assessment, undisputed or objective is not independent validation. Applying the law to the facts must identify every offence or duty element. A decision’s status in a case-record system does not document its lawfulness or enforcement.

2.5 Accounts that must not be added together

Oversight activities, decision errors, people, losses and responsibility are five different accounts. One person may have several cases, and the same case may appear at municipal, Ankestyrelsen, court and international review levels. An error may concern substance, procedure, registration or timing. Each may have legal significance, but they do not mean the same thing. Complaint outcomes must also distinguish alteration, remittal, affirmance with criticism, rejection and cessation.

All fractions in the report retain their denominator and measurement period. Subcriteria may overlap. Rounded percentages are not converted into supposedly exact person counts. Changes in methodology, new registration categories and revised annual figures must be stated before a trend is called an improvement. Continuing and unfinished cases cannot be deleted from an account of time because an average covers closed cases only.

2.6 Defined corrections to strengthen the case

A remittal does not automatically establish every element of a claim that the original decision was unlawful. The specific grounds for remittal must be shown. The supervisory authority's rejection rate is not recast as ordinary citizens' complaints. The general case-processing deadlines under the Danish Act on Legal Protection and Administration in Social Matters derive from § 3 and the supplementary § 3 a; § 7 a performs a different follow-up function. § 23 of the Public Administration Act provides a 14-day time limit for requesting written reasons for an oral decision. ([97]; [71])

The transitional rule in the new psychologist authorisation scheme allows certain persons who were entitled to use the title at the end of 2025 to use it until 31. December 2028. A reference to human rights does not automatically establish entitlement to a particular treatment, a particular medicinal product or a particular diagnosis. Application of the EU Charter requires a connection with EU law; Article 41 is addressed to the Union’s institutions. These specific corrections remove no documented error by an authority. ([119]; [59]; Kristensen [9]; Kristensen [11])

2.7 Total number of checks and corrections in 2006 to 2025

Aggregate record total – gross sum of selected oversight and correction records from 2006 to 2025: 202.870.

The table below adds up the exact whole numbers in the selected annual and oversight statistics. A period with the same figures reproduced in several annual reports is counted once. An updated version of a portal and an older annual report are not added together. Remittal, amendment, criticism and express illegality have their own columns or subtotals. Reports published in 2026 may be included where they report decisions or processes up to and including 2025. The year of the event may precede the year of the decision.

Control tracks	Years counted	Number	Counting unit
Municipal social and employment complaints	2006-2012 and 2014- 2025	134.436	Decision entry: amended/annulled or remitted
Psychiatric coercion	2011-2025 national; selected regional years 2008-2010	6.824	Setting aside or a separate procedural-unlawfulness/duration component
Complaints about police conduct	2006–2025	354	Decision involving criticism

Control tracks	Years counted	Number	Counting unit
Complaints about police operational decisions	2019–2020	711	First-instance outcomes granting full/partial relief
Disciplinary complaints concerning healthcare professionals	2006, 2011–2012, 2014–2017 and 2021–2025	6.413	Critical case outcomes in selected categories
Healthcare pathway and treatment-facility complaints	2011- 2017 and 2021- 2025	9.061	Critical pathway/facility outcome
Tax appeals	Favourable findings 2014–2025; separate remittals 2025	36.012	35.759 favourable findings + 253 remittals
Immigration Appeals Board	2013–2021	6.265	1.834 overturnings + 4.431 remittals
Parliamentary Ombudsman	2006–2025	2.794	Case file in the criticism/request/recommendation, etc. group
Total sum of entries	Selected periods within 2006–2025	202.870	Gross sum of the above registrations

The sum has a precise, limited function: it shows how many adverse or corrective review outcomes the named source series actually record. It is not a shared union of events or people. Healthcare complaints concerning individuals and treatment processes may concern the same treatment; the Ombudsman may examine a case from another track. Reopenings and repeated appeals may also concern the same individual. The outcome class alone does not identify the precise grounds of error or legal consequence. These entries are specific review results; individual legal classification proceeds from the original decision’s documented facts to the relevant rule, act, departure, consequence and responsibility.

The more legally direct psychiatric component shows 6.550 recorded instances in which measures were set aside in the selected national and regional tables, a further 142 formally unlawful approvals in 2024–2025, and 132 separately identified decisions setting aside the duration in 2017 and 2025. Each part of the decisions must still be linked to the intervention and subsequent review. The police's 354 decisions expressing criticism remain their own documented category of criticism. A broad category of alterations and remittals is thus not used to conceal the more direct findings of unlawfulness and criticism.

2.8 Municipal appeal decisions year by year

The municipal subtotal is 134.436 = 51.823 in 2006–2012 + 82.613 in 2014–2025. The selected series contains 54.663 amended/annulled outcomes and 79.773 remitted outcomes among 479.580 registrations of cases decided on the merits. The earlier social boards and employment appeals boards and the later Ankestyrelsen data differ in jurisdiction and legislative coverage. A homogeneous twenty-year error rate is therefore not calculated. Municipalities' own corrections before referral to the appeal body are not included. The missing year 2013 is a gap, not zero overturnings.

Decision year	Amended/annulled	Remitted	Total alterations/remittals	Outcomes on the merits	Source
2006	2.896	3.497	6.393	24.915	[143]
2007	2.295	3.567	5.862	20.416	[144]
2008	2.679	3.991	6.670	24.494	[144]

Decision year	Amended/annulled	Remitted	Total alterations/remittals	Outcomes on the merits	Source
2009	3.114	4.318	7.432	28.452	[144]
2010	3.406	4.900	8.306	32.764	[144]
2011	4.068	4.890	8.958	32.116	[144]
2012	3.601	4.601	8.202	32.066	[145]
2014	3.964	4.607	8.571	35.590	[146]
2015	3.235	3.994	7.229	27.100	[146]
2016	2.935	3.640	6.575	22.491	[146]
2017	3.107	4.636	7.743	25.815	[146]
2018	3.757	4.438	8.195	26.861	[146]
2019	3.409	4.412	7.821	24.038	[146]
2020	2.746	4.170	6.916	23.608	[146]
2021	2.129	3.351	5.480	20.995	[146]
2022	2.045	3.510	5.555	18.415	[146]
2023	2.037	3.662	5.699	19.210	[146]
2024	1.473	3.934	5.407	17.307	[146]
2025	1.767	5.655	7.422	22.927	[146]
Total	54.663	79.773	134.436	479.580	One selected source version per year; 2013 omitted

A new official CSV extract from Talportalen was checked on 11 October 2026. All 12 national totals for 2014–2025 and the four outcome columns match the selected register version of 7 October 2026. There are 26 selected legislative groups; a group without data is omitted from the export itself. Only Whole country/Total is included; no municipality is added. The dynamic portal series is fixed to this extract. Later corrections may produce different figures. The earlier annual-report series for 2018–2024 totals 45.022 overturnings, while the selected portal version for the same years totals 45.073. They are versions of the same annual series and are not both counted. Reproduction must use the same years, legislative groups, authority level and outcome filters. Both complete annual originals for 2006 and 2012 have been obtained from the specified public web-archive copies and their original tables checked. They confirm 6.393 and 8.202. A specific internal discrepancy in the 2006 table 4 is retained: the rows broken down by legislation total 2.897 amended/annulled outcomes, whereas the national total and table 1 give 2.896. The calculation uses the repeatedly confirmed national total; the difference is one registration and not a newly documented oversight outcome. The earlier and later annual series are presented with the jurisdictional scope of their respective sources; they are not presented as identical statistical populations.

2013 has been examined separately in both annual originals. Statsforvaltningen records 7.696 employment appeals board decisions and 9.084 social board decisions in the first half of the year, a total of 16.780. The table does not show how many were upheld, amended/annulled, remitted or rejected. Ankestyrelsen's annual report refers to 11.000 closed municipal appeals after the transfer from 1 July, without the required

outcome matrix and denominator of cases decided on the merits; the degree of rounding is not specified. The annual report's 22.765 case closures across all appropriation areas include other appeal areas. Earlier board decisions on matters of principle could also be reviewed again by Ankestyrelsen. These activity figures must therefore not be added as overturnings or as one homogeneous full-year population. The current portal covers 2014 onwards. A precise figure for 2013 requires two original half-year extracts with the same outcome definition and exclusion of repeat counting at second instance. [147]; [148].

2.9 Psychiatric coercion and duration

6.824 = 6.362 national decisions setting aside interventions in 2011–2025 + 188 decisions setting aside interventions in the delimited regional samples for 2008–2010 + 46 and 96 approvals unlawful as to formalities in 2024 and 2025 respectively + 50 and 82 separate decisions setting aside duration in 2017 and 2025 respectively. The 50 from 2017 are expressly excluded from the main statistics in the original. The 2023 total includes duration under the counting rule then in force; a separate 2023 duration series is therefore not added. 2006–2010 is not a complete national series.

Year or period	Number	Source category	Source
2011	313	The Board’s nationwide regional breakdown of decisions set aside	[149]
2012	244	The Board’s nationwide regional breakdown of decisions set aside	[149]
2013	352	The Board’s nationwide regional breakdown of decisions set aside	[149]
2014	462	The Board’s nationwide regional breakdown of decisions set aside	[150]
2015	723	The Board’s nationwide regional breakdown of decisions set aside	[151]
2016	513	The Board’s nationwide regional breakdown of decisions set aside	[151]
2017	382	The Board’s nationwide regional breakdown of decisions set aside	[151]
2018	370	The Board’s nationwide regional breakdown of decisions set aside	[152]
2019	362	The Board’s nationwide regional breakdown of decisions set aside	[153]
2020	522	The Board’s nationwide regional breakdown of decisions set aside	[154]
2021	464	The Board’s nationwide regional breakdown of decisions set aside	[154]
2022	460	The Board’s nationwide regional breakdown of decisions set aside	[154]
2023	497	The Board’s nationwide regional breakdown of decisions set aside	[51]
2024	279	The Board’s nationwide regional breakdown of decisions set aside	[51]
2025	419	The Board’s nationwide regional breakdown of decisions set aside	[51]
2008	8	Delimited regional count, other regions missing	[155]
2009	4	Delimited regional count, other regions missing	[155]
2009	51	Delimited regional count, other regions missing	[156]
2010	2	Delimited regional count, other regions missing	[155]
2010	34	Delimited regional count, other regions missing	[156]
2010	89	Delimited regional count, other regions missing	[157]
2017	50	Duration set aside	[151]

Year or period	Number	Source category	Source
2024	46	Approved, formally illegal	[51]
2025	96	Approved, formally illegal	[51]
2025	82	Duration set aside	[51]
Total	6.824	Sum of selected registrations	Year and category delimitations above

Source discrepancies are retained: the regional table for 2017 gives 382 decisions set aside, while the type table gives 383; the calculation uses 382. In 2024, regional totals and totals by type also differ; the selected regional series is used once. Approvals found procedurally unlawful belong to a different outcome category from decisions set aside. Unpublished duration components or those unreconciled across versions are not set to zero and are not added without documented separation. A board’s outcome concerning part of a decision does not necessarily represent a separate patient or incident.

2.10 Police and complaint scrutiny

There are 354 decisions containing criticism in conduct complaints in 2006–2025. The 711 outcomes finding in the party’s favour in complaints about police operational decisions cover only 2019–2020: 380 in 2019 and 331 in 2020. Second-instance findings in the party’s favour in complaints about operational decisions are not added, because the same case may be included in the first-instance figure. Softer outcomes expressing regret or finding inappropriateness are not included in the selected criticism total. Disciplinary examples discussed in the report are not counted as additional decisions on top of the annual statistics.

Year or period	Number	Source category	Source
2006	7	decisions on conduct complaints involving criticism	[158]
2007	14	decisions on conduct complaints involving criticism	[158]
2008	8	decisions on conduct complaints involving criticism	[158]
2009	5	decisions on conduct complaints involving criticism	[158]
2010	3	decisions on conduct complaints involving criticism	[158]
2011	7	decisions on conduct complaints involving criticism	[158]
2012	25	decisions on conduct complaints involving criticism	[159]
2013	22	decisions on conduct complaints involving criticism	[160]
2014	30	decisions on conduct complaints involving criticism	[161]
2015	21	decisions on conduct complaints involving criticism	[162]
2016	24	decisions on conduct complaints involving criticism	[163]
2017	17	decisions on conduct complaints involving criticism	[164]
2018	11	decisions on conduct complaints involving criticism	[165]
2019	19	decisions on conduct complaints involving criticism	[166]
2020	9	decisions on conduct complaints involving criticism	[167]

Year or period	Number	Source category	Source
2021	15	decisions on conduct complaints involving criticism	[168]
2022	30	decisions on conduct complaints involving criticism	[169]
2023	16	decisions on conduct complaints involving criticism	[170]
2024	45	decisions on conduct complaints involving criticism	[171]
2025	26	decisions on conduct complaints involving criticism	[172]
2019	380	first-instance appeal outcomes involving wholly/partly favourable findings	[173]
2020	331	first-instance appeal outcomes involving wholly/partly favourable findings	[174]
Total	1.065	Sum of selected registrations	Year and category delimitations above

2.11 Health professionals and treatment sites

The precisely counted selected health-complaint categories yield 6.413 adverse disciplinary/individual-related outcomes and 9.061 adverse case-history/treatment-site outcomes. In the earlier years, adverse outcomes comprise the specified categories of criticism, formal admonition and any requests for prosecution. In the more recent portal years, closures involving refunds and criticism are included as a mutually exclusive final category. Partial decisions concerning individuals are not added on top of case outcomes. The published series also covers private treatment and, during parts of the period, Greenland/the Faroe Islands; it is therefore presented as the complaint system’s records, rather than a count confined to public employees or incidents in Denmark. Complaints concerning treatment sites and individuals may concern the same treatment.

Year or period	Number	Source category	Source
2006	569	critical case decisions;	[175]
2011	716	critical case decisions;	[176]
2012	531	critical case decisions;	[177]
2014	445	critical case decisions;	[178]
2015	414	critical case decisions;	[179]
2016	464	critical case decisions;	[180]
2017	451	critical case decisions;	[181]
2021	661	adverse case closures	[182]
2022	675	adverse case closures	[182]
2023	545	adverse case closures	[182]
2024	524	adverse case closures	[182]
2025	418	adverse case closures	[182]
2011	73	treatment site decisions with criticism;	[178]
2012	483	treatment site decisions with criticism;	[178]

Year or period	Number	Source category	Source
2013	466	treatment site decisions with criticism;	[178]
2014	527	treatment site decisions with criticism;	[178]
2015	763	treatment site decisions with criticism;	[179]
2016	732	treatment site decisions with criticism;	[180]
2017	599	treatment site decisions with criticism;	[181]
2021	1.039	Closures of treatment-course cases with criticism	[182]
2022	1.204	Closures of treatment-course cases with criticism	[182]
2023	1.076	Closures of treatment-course cases with criticism	[182]
2024	1.006	Closures of treatment-course cases with criticism	[182]
2025	1.093	Closures of treatment-course cases with criticism	[182]
Total	15.474	Sum of selected registrations	Year and category delimitations above

The disciplinary series does not contain the precisely reconciled years 2007–2010, 2013 and 2018–2020 in this subtotal; the treatment-course series lacks 2006–2010 and 2018–2020. Register rows for 2021–2025 are fixed to the STPK i tal version of 5. October 2026 and identify category and decision year. A later portal version must not be mixed into the same sum. Missing years are unquantified criticism, not exoneration. Specific attribution to public authorities and entitlement to remedial action must be established in each case.

2.12 Tax appeals

35.759 wholly or partly favourable outcomes in 2014–2025, together with 253 separately recorded remittals in 2025, yield 36.012 oversight and correction entries. The five appeal bodies covered by Skatteankestyrelsen are included. Remittals before 2025 are not available as a consistent separate category and are not assumed to be zero. The same appeal number may be divided into several appeals; a favourable finding requires verification against the original material before its cause is described as a specific original illegality.

Year or period	Number	Source category	Source
2014	1.792	decisions with wholly/partly favourable findings	[183]
2015	2.985	decisions with wholly/partly favourable findings	[184]
2016	3.968	decisions with wholly/partly favourable findings	[185]
2017	4.182	decisions with wholly/partly favourable findings	[186]
2018	3.120	decisions with wholly/partly favourable findings	[187]
2019	3.197	decisions with wholly/partly favourable findings	[188]
2020	3.071	decisions with wholly/partly favourable findings	[189]
2021	2.553	decisions with wholly/partly favourable findings	[190]
2022	2.873	decisions with wholly/partly favourable findings	[191]

Year or period	Number	Source category	Source
2023	2.970	decisions with wholly/partly favourable findings	[192]
2024	2.302	decisions with wholly/partly favourable findings	[193]
2025	2.746	decisions with wholly/partly favourable findings	[114]
2025	253	remittal outcomes	[114]
Total	36.012	Sum of selected registrations	Year and category delimitations above

2.13 Overturnings and remittals by the Immigration Appeals Board

The selected raw outcome figures for 2013–2021 yield 1.834 overturnings and 4.431 remittals, a total of 6.265. Family, employment, visa and EU cases are included in the years in which the categories appear. The subsequently published rounded percentages for 2022–2025 are not converted into invented whole numbers. Matters predating the board’s establishment and missing later raw figures remain outstanding data requirements.

Year or period	Number	Source category	Source
2013	229	overturned in Family Reunification etc.	[194]
2013	34	overturned in Business, etc.	[194]
2014	202	overturned in Family Reunification etc.	[195]
2014	31	overturned in Business, etc.	[195]
2015	159	overturned in Family Reunification etc.	[196]
2015	26	overturned in Business, etc.	[196]
2016	166	overturned in Family Reunification etc.	[197]
2016	20	overturned in Business, etc.	[197]
2017	166	overturned in Family Reunification etc.	[198]
2017	36	overturned in Business, etc.	[198]
2017	5	overturned in Visum	[198]
2018	69	overturned in Family Reunification etc.	[199]
2018	14	overturned in Business, etc.	[199]
2018	11	overturned in Visum	[199]
2019	49	overturned in Family Reunification etc.	[200]
2019	7	overturned in Business, etc.	[200]
2019	5	overturned in Visum	[200]
2019	1	overturned in EU	[200]
2020	73	overturned in Family Reunification etc.	[201]

Year or period	Number	Source category	Source
2020	1	overturned in Business, etc.	[201]
2020	9	overturned in Visum	[201]
2020	17	overturned in EU	[201]
2021	396	overturned in Family Reunification etc.	[202]
2021	42	overturned in Business, etc.	[202]
2021	7	overturned in Visum	[202]
2021	59	overturned in EU	[202]
2013	293	remitted in Family Reunification etc.	[194]
2013	165	remitted in Employment etc.	[194]
2014	242	remitted in Family Reunification etc.	[195]
2014	165	remitted in Employment etc.	[195]
2015	302	remitted in Family Reunification etc.	[196]
2015	104	remitted in Employment etc.	[196]
2016	383	remitted in Family Reunification etc.	[197]
2016	109	remitted in Employment etc.	[197]
2017	402	remitted in Family Reunification etc.	[198]
2017	76	remitted in Employment etc.	[198]
2017	17	remitted in Visa cases	[198]
2018	409	remitted in Family Reunification etc.	[199]
2018	35	remitted in Employment etc.	[199]
2018	25	remitted in Visa cases	[199]
2019	453	remitted in Family Reunification etc.	[200]
2019	22	remitted in Employment etc.	[200]
2019	21	remitted in Visa cases	[200]
2019	43	remitted in EU cases	[200]
2020	384	remitted in Family Reunification etc.	[201]
2020	25	remitted in Employment etc.	[201]
2020	41	remitted in Visa cases	[201]
2020	85	remitted in EU cases	[201]
2021	401	remitted in Family Reunification etc.	[202]
2021	51	remitted in Employment etc.	[202]

Year or period	Number	Source category	Source
2021	57	remitted in Visa cases	[202]
2021	121	remitted in EU cases	[202]
Total	6.265	Sum of selected registrations	Year and category delimitations above

2.14 The Ombudsman's regular audit trail

In 2006–2025, the Parliamentary Ombudsman had a total of 2.794 closed registered cases in the published category of criticism, recommendations, advice etc. The category is broader than purely established breaches of law. It documents a consistent adverse or corrective oversight track. Published cases of principle and breakdowns by authority are not counted again.

Decision year	Criticism/recommendation etc.	Source
2006	217	[203]
2007	279	[204]
2008	162	[205]
2009	190	[206]
2010	137	[207]
2011	153	[208]
2012	83	[209]
2013	124	[210]
2014	166	[211]
2015	156	[212]
2016	153	[213]
2017	135	[214]
2018	121	[215]
2019	105	[216]
2020	138	[217]
2021	78	[218]
2022	126	[219]
2023	92	[220]
2024	81	[221]
2025	98	[222]
Total	2.794	All 20 decision years 2006-2025

2.15 Adjudicated international violations and separate protection findings

The ECtHR count for judgment years 2006–2025 contains 25 judgment records finding violations, but 24 distinct courses with a final finding of a violation, calculated by reference to finality status on 11. October 2026. Mortensen was delivered on 21. October 2025 and became final on 21. January 2026. The Savran Chamber judgment of 2019 and the Grand Chamber judgment of 2021 concern the same application number 57467/15 and are not two distinct courses. The Chamber's conditional Article 3 finding was replaced by the final Grand Chamber judgment finding a violation of Article 8 and no violation of Article 3. The final evidentiary status under the Convention follows the last relevant judgment. A violation arising from an expulsion decision does not in itself prove that removal was carried out.

Judgment year	Documents of judgments finding violations	Source
2006	2	[223]
2007	0	[224]
2008	2	[225]
2009	3	[226]
2010	0	[227]
2011	1	[228]
2012	0	[229]
2013	0	[230]
2014	0	[231]
2015	0	[232]
2016	1	[233]
2017	0	[234]
2018	0	[235]
2019	2	[236]
2020	1	[237]
2021	3	[238]
2022	1	[239]
2023	3	[240]
2024	4	[241]
2025	2	[242]
Total	25 judgment documents /24 final proceedings	The Savran case is counted once

For the UN's six relevant treaty committees, the checked decision sample within the 2006–2025 study period contains 57 favourable Views on the merits:7 from the Committee against Torture, 31 from the Human Rights Committee, 3 from the Committee on the Elimination of Discrimination against Women, 6 from the Committee on the Elimination of Racial Discrimination, 8 from the Committee on the Rights of the Child and 2 from the Committee on the Rights of Persons with Disabilities. 20 contain only an established violation finding, three contain both an established and an expressly forward-looking finding, and 34 contain only a forward-looking or conditional protective finding. Thus 23 contain an expressly established violation finding.

The adoption dates in this list run from 6. March 2006 to 24. May 2024; none of the 57 was separately adopted in 2025. H.H. was adopted in May 2024, although the original document was published in January 2025. The list is a selection checked against the originals, not a guarantee that every favourable UN decision has been captured. A finding of a legal or procedural violation in a child-related case does not prove that the anticipated physical harm occurred. F.K., CAT/C/70/D/743/2016, contains a separate finding of a breach of the Article 22 procedure in a case whose substantive complaint was rejected, and falls outside the 57 views on the merits. UN committee views and the ECtHR's binding judgments have different legal functions. They are presented as international findings of responsibility and are not added to the national record series as new, deduplicated instances of harm to individuals.

The Savran originals: [243]; [244].

The international total must be reproduced using case numbers and outcomes in [245] and [246].

The 24 distinct ECtHR proceedings below are identified by application number, judgment date, Article and central finding. Multiple applicants or Article findings in the same judgment do not create additional proceedings. Where fresh extraction of the original was blocked, the specific verification source is an official judgment summary or an official execution resolution. The public HUDOC link to the original judgment is retained, and no paragraph numbers are invented. The judgment year indicates the time of review and must not be converted into the date of the underlying event.

Date of judgment	Rule violated	Course and documented finding	Original and verification source
2006-01-11	ECHR 11	Sørensen and Rasmussen v. Denmark [Grand Chamber]; 52562/99, 52620/99. Denmark did not adequately protect the two applicants' negative freedom of association against private employers' closed-shop agreements. The State's positive obligation to protect was breached.	[247]; [248]
2006-09-28	ECHR 6 § 1	Iversen v. Denmark; 5989/03. The civil medical compensation proceedings lasted almost eight years and nine months. Referrals to the Medico-Legal Council and the National Board of Industrial Injuries substantially prolonged the proceedings, and both were public authorities. Special diligence was required because of the personal injury and its consequences. The total duration violated Article 6 § 1. Final 2006-12-28.	[249]; [250]; [251]
2008-12-11	ECHR 6 § 1	Hasslund v. Denmark; 36244/06. The criminal proceedings lasted approximately 10 years and 9 months. Consideration by the Appeals Permission Board took approximately 1 year and 8 months, including eight months of inactivity due to an error. The overall duration was unreasonable. Final 2009-03-11.	[252]; [253]
2008-12-11	ECHR 6 § 1	Moesgaard Petersen v. Denmark; 32848/06. The total duration of the criminal proceedings, almost ten years, exceeded a reasonable time. The ECtHR singled out in particular the eight-month period during which the case lay dormant before the Appeals Permission Board because of an error. Final on 2009-03-11.	[254]; [255]
2009-01-22	ECHR 6 § 1; 13	Christensen v. Denmark; 247/07. Civil medical compensation proceedings lasted almost eleven years through two levels of jurisdiction. The courts themselves were responsible for monitoring progress. The applicant did not have an adequate, effective and accessible remedy against the delay. Final 2009-04-22.	[256]; [257]; [258]

Date of judgment	Rule violated	Course and documented finding	Original and verification source
2009-03-26	ECHR 6 § 1; 13; P1-1	Valentin v. Denmark; 26461/06. The bankruptcy proceedings lasted approximately 17 years and 4 months, and the applicant was deprived of control over his property for almost seventeen years. The duration, the absence of an effective remedy and the disproportionate burden on the right to property constituted three Convention findings. Final on 2009-06-26.	[259]; [258]
2009-07-02	ECHR 6 § 1	Nielsen v. Denmark; 44034/07. A civil compensation action concerning company asset stripping lasted approximately 11 years and 2 months before a single instance and ended on 10 December 2008. The overall duration was unreasonable. Final on 2009-10-02.	[260]; [258]
2011-06-14	ECHR 8	Osman v. Denmark; 38058/09. The authorities refused to restore a minor girl’s residence permit after a stay in Kenya initiated by her parents. Insufficient weight was given to her strong ties to Denmark, age and interests. Final 2011-09-14.	[261]; [262]
2016-05-24	ECHR 14 taken in conjunction with 8	Biao v. Denmark [Grand Chamber]; 38590/10. The 28-year rule gave an advantage to people of Danish origin that had a disparate impact on other ethnic groups. Denmark had not demonstrated the requisite objective and reasonable justification for the indirect ethnic discrimination.	[263]; [263]; [264]
2019-07-09	ECHR 5 § 1	Tim Henrik Bruun Hansen v. Denmark; 51072/15. In connection with continued preventive detention, the High Court had not attempted to obtain a fresh external medical assessment. The facts had not been sufficiently established to demonstrate continued necessity and the requisite connection between the judgment and the deprivation of liberty. Final 2019-10-09.	[265]; [266]
2020-09-15	ECHR 3 substantive	Aggerholm v. Denmark; 45439/18. A psychiatric patient was subjected to belt restraint for almost 23 hours. The state did not document that the continued restraint was necessary. The violation finding concerns its continuation; it must not be presented as a finding that its initial use was unlawful from the first minute. Final 2020-12-15.	[267]; [136]
2021-07-09	ECHR 8	M.A. v. Denmark [Grand Chamber]; 6697/18. A general three-year waiting period for family reunification for persons with temporary subsidiary protection was applied without a sufficient individual balancing exercise. Denmark did not fulfil its positive obligation to ensure a fair balance in respect of family life.	[268]; [268]; [269]
2021-09-14	ECHR 8	Abdi v. Denmark; 41643/19. A settled resident who had arrived in Denmark at the age of four received an expulsion order with a permanent re-entry ban. The balancing of his ties and the circumstances justifying expulsion did not satisfy Article 8. Final 2022-01-17.	[270]; [271]; [272]; [273]; [274]
2021-12-07	ECHR 8	Savran v. Denmark [Grand Chamber]; 57467/15. In the expulsion with a permanent re-entry ban, the mental illness and its significance for criminal culpability were not sufficiently incorporated into the balancing exercise. The Grand Chamber found a violation of Article 8; it did not find a violation of Article 3.	[275]; [276]; [277]

Date of judgment	Rule violated	Course and documented finding	Original and verification source
2022-12-06	ECHR 8, the two children's private life	K.K. and Others v. Denmark; 25212/21. The two children did not have sufficient alternative access to legal recognition of their relationship with the intended mother. The general prohibition on stepchild adoption following commercial surrogacy created legal uncertainty and failed to give sufficient weight to the children's specific interests. Final 2023-03-06.	[278]; [279]
2023-09-05	ECHR 8	Noorzae v. Denmark; 44810/20. An Afghan national who had strong ties to Denmark from a young age and weak ties to Afghanistan was issued an expulsion decision with a twelve-year re-entry ban. The specific proportionality assessment did not justify the interference. Final on 2023-12-05.	[280]; [281]; [273]
2023-09-05	ECHR 8	Sharifi v. Denmark; 31434/21. An Afghan national with strong ties to Denmark from a young age and weak ties to Afghanistan was issued an expulsion decision with a twelve-year re-entry ban. The specific proportionality assessment did not justify the interference. Final on 2023-12-05.	[282]; [281]; [273]
2023-10-03	ECHR Article 3, substantive; Article 3, procedural	El-Asmar v. Denmark; 27753/19. The state did not establish that the use of pepper spray against a prisoner was strictly necessary. The investigation of the use of force and compliance with safety rules was inadequate. The ECtHR found both a substantive and a procedural breach of Article 3. Final 2024-01-03.	[283]; [284]
2024-04-09	ECHR 8	Nguyen v. Denmark; 2116/21. An expulsion decision imposing a twelve-year re-entry ban gave insufficient weight to the applicant's long residence, subordinate role in the offences and care for an adult daughter with a disability and a minor child. The High Court had not carried out the necessary assessment of the competing considerations in the particular case. Final on 2024-07-09.	[285]; [273]; [286]
2024-04-09	ECHR 8	Sarac v. Denmark; 19866/21. A settled resident who had arrived in Denmark at the age of seven received an expulsion order with a permanent re-entry ban following a drugs and weapons case. The national proportionality assessment did not satisfy Article 8. Final 2024-07-09.	[287]; [286]
2024-10-15	ECHR Article 3, procedural; Article 8, procedural	Daugaard Sørensen v. Denmark; 25650/22. Three successive acknowledged errors in the prosecution service's handling meant that the charge had to be dropped. The procedural response to the rape complaint was so deficient that Denmark breached its positive obligations to protect under Articles 3 and 8. Final 2025-01-15.	[288]; [289]
2024-11-12	ECHR 8	Sharafane v. Denmark; 5199/23. A man born in Denmark was issued with an expulsion decision. A time-limited entry ban does not remedy the seriousness of the interference when a later return is in practice merely theoretical. The specific balancing exercise did not satisfy Article 8. Final 2025-03-17.	[290]; [291]; [292]; [293]
2025-05-27	ECHR 2, substantive limb, positive obligation	Kalkan v. Denmark; 51781/22. The applicant's son died in prison in January 2011 after being restrained in a prone position with a leg lock. Denmark had not provided clear and sufficient instructions on the method or adequately trained staff. This was a breach of the state's positive obligation under Article 2. Final 2025-08-27.	[294]; [295]

Date of judgment	Rule violated	Course and documented finding	Original and verification source
2025-10-21	ECHR 10	Mortensen v. Denmark; 16756/24. The Danish courts did not conduct a sufficient balancing exercise concerning freedom of expression when convicting the applicant of defamation over a post concerning the administration of justice and the limits of freedom of expression. The criminal conviction, fine and compensation were disproportionate taken together. Final 2026-01-21.	[296]; [297]

The 57 UN cases on the merits below have been checked against each public original decision. CAT denotes the Committee against Torture; CCPR the Human Rights Committee; CEDAW the Committee on the Elimination of Discrimination against Women; CERD the Committee on the Elimination of Racial Discrimination; CRC the Committee on the Rights of the Child; CRPD the Committee on the Rights of Persons with Disabilities. Classification follows the operative majority finding. The article reference belongs to the named treaty and is not an ECHR article. A document may have several authors and several article violations; it is counted as one communication.

Adopted	Finding category	Case, treaty provision and operative finding	Public original
2006-03-06	Violation found	CERD; Mohamed Hassan Gelle; 34/2004. Articles 2(1)(d), 4, 6. Finding of a violation of Articles 2(1)(d), 4 and 6 in the authorities' handling of a complaint about racist statements; requirement for compensation and effective enforcement.	[298]
2007-08-08	Violation found	CERD; Murat Er; 40/2007. Articles 2(1)(d), 5(e)(v), 6. Finding of racial discrimination in access to education/work placements and insufficiently effective investigation and review; Articles 2(1)(d), 5(e)(v) and 6.	[299]
2010-07-22	Prospective/conditional	CCPR; Mohamed El-Hichou; 1554/2007. Articles 23, 24. Implementation of the refusal of family reunification between the minor and his father and of the departure order would violate Articles 23 and 24. The operative finding is expressly conditional on implementation.	[300]
2010-08-13	Violation found	CERD; Saada Mohamad Adan; 43/2008. Articles 2(1)(d), 4, 6. Finding of a violation of Articles 2(1)(d), 4 and 6 in the authorities' handling of racist statements and a requirement for effective protection and a remedy.	[301]
2010-11-15	Prospective/conditional	CAT; Said Amini; 339/2008. Article 3 (prospective). According to the Committee’s operative finding, removal to Iran would violate the specified Convention rights; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[302]
2012-03-06	Violation found	CERD; Mahali Dawas and Yousef Shava; 46/2009. Articles 2(1)(d), 6. Finding of a lack of effective protection, investigation and remedy following a violent attack on a refugee family; Articles 2(1)(d) and 6. No separate finding under Article 4(a).	[303]
2012-11-23	Prospective/conditional	CAT; K. H.; 464/2011. Article 3 (prospective). According to the Committee’s operative finding, removal to Afghanistan would violate the specified Convention rights; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[304]

Adopted	Finding category	Case, treaty provision and operative finding	Public original
2014-03-26	Prospective/conditional	CCPR; X; 2007/2010. Article 7. According to the Committee's operative finding, removal to Eritrea would violate the specified Convention rights; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[305]
2015-04-01	Violation found	CCPR; Q; 2001/2010. Article 26. Established discrimination in the handling of an application for exemption from the language requirement for naturalisation; Article 26.	[306]
2015-07-16	Violation found	CCPR; A. H.; 2370/2014. Article 7. The removal to Afghanistan already carried out violated Article 7. Reconsideration, prompt return and compensation are specified as remedies.	[307]
2015-07-22	Prospective/conditional	CCPR; Warda Osman Jasin; 2360/2014. Article 7. According to the Committee's operative finding, removal to Italy would violate the specified Convention rights; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[308]
2015-07-22	Prospective/conditional	CCPR; X; 2389/2014. Article 7. According to the Committee's operative finding, removal to Iran would violate the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or sufficient individual risk assessment.	[309]
2015-07-23	Prospective/conditional	CCPR; Osayi Omo-Amenaghawon; 2288/2013. Articles 6, 7. According to the Committee's operative finding, removal to Nigeria would violate the specified Convention rights; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[310]
2015-07-23	Prospective/conditional	CCPR; H. E. A. K.; 2343/2014. Article 7. According to the Committee's operative finding, removal to Egypt would violate the specified Convention rights; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[311]
2015-11-04	Prospective/conditional	CCPR; Jenirthan Rasappu and Jenarthan Rasappu; 2258/2013. Article 7. According to the Committee's operative findings, removal to Sri Lanka would be contrary to the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or adequate individual risk assessment.	[312]
2015-11-19	Violation found	CEDAW; A.; 53/2013. Article 2(c), (d). The Committee finds a failure to comply with Article 2(c) and (d) and a violation of the woman's rights. The remedy includes refraining from forcible removal to Pakistan.	[313]
2015-11-23	Established and forward-looking	CAT; F.K.; 580/2014. Article 3 (prospective protection); 12 read in conjunction with 16 (violation found). The Committee requires Denmark to refrain from removal to Turkey under Article 3 and at the same time finds an already committed violation of Article 12 read in conjunction with Article 16 through failure to investigate the treatment by the police.	[314]
2016-02-22	Violation found	CEDAW; M. W.; 46/2012. Article 2 read in conjunction with 1, 5(a), (b), 16(1)(d). A violation of the rights of the mother and her minor son was found in a course concerning violence, protection, custody and access to judicial review.	[315]

Adopted	Finding category	Case, treaty provision and operative finding	Public original
2016-03-29	Prospective/conditional	CCPR; Abdilafir Abubakar Ali and Mayul Ali Mohamad; 2409/2014. Article 7. According to the Committee's operative finding, removal to Italy would violate the specified Convention rights; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[316]
2016-05-13	Prospective/conditional	CAT; J. N.; 628/2014. Article 3 (prospective). According to the Committee's operative finding, removal to Sri Lanka would violate the specified Convention rights; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[317]
2016-07-01	Prospective/conditional	CCPR; E. U. R.; 2469/2014. Article 7. Removal to Afghanistan would, according to the Committee's operative finding, violate the stated treaty rights; Denmark must refrain from removal and ensure a fresh or adequate individual risk assessment.	[318]
2016-07-04	Prospective/conditional	CCPR; A. A. S.; 2464/2014. Article 7. Removal to Somalia would, according to the Committee's operative finding, violate the stated treaty rights; Denmark must refrain from removal and ensure a fresh or adequate individual risk assessment.	[319]
2016-07-07	Prospective/conditional	CCPR; Ms. Obah Hussein Ahmed; 2379/2014. Article 7. Removal to Italy would, according to the Committee's operative finding, violate the stated treaty rights; Denmark must refrain from removal and ensure a fresh or adequate individual risk assessment.	[320]
2016-07-12	Prospective/conditional	CCPR; M. K. H.; 2462/2014. Article 7. According to the Committee's operative finding, removal to Bangladesh would violate the specified Convention rights; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[321]
2016-10-28	Prospective/conditional	CCPR; R. A. A. and Z. M.; 2608/2015. Article 7. According to the Committee's operative finding, removal to Bulgaria would violate the specified Convention rights; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[322]
2016-11-25	Prospective/conditional	CAT; M. B., A. B., D. M. B. and D. B.; 634/2014. Article 3 (prospective). According to the Committee's operative finding, removal to Russia would violate the stated Convention rights; Denmark must refrain from removal and ensure a fresh or sufficient individual risk assessment.	[323]
2017-03-10	Prospective/conditional	CCPR; Raziyeh Rezaifar; 2512/2014. Article 7. According to the Committee's operative findings, removal to Italy would be contrary to the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or adequate individual risk assessment.	[324]
2017-03-10	Prospective/conditional	CCPR; Y. A. A. and F. H. M.; 2681/2015. Article 7. According to the Committee's operative finding, removal to Italy would violate the specified Convention rights; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[325]

Adopted	Finding category	Case, treaty provision and operative finding	Public original
2017-03-16	Prospective/conditional	CCPR; F and G; 2530/2015. Article 7. According to the Committee’s operative finding, removal to Egypt would violate the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or sufficient individual risk assessment.	[326]
2017-05-12	Prospective/conditional	CAT; A. M. D. et al.; 653/2015. Article 3 (prospective). According to the committee's operative finding, removal to Russia would violate the Convention rights specified; Denmark must refrain from removal and ensure a renewed or adequate individual risk assessment.	[327]
2017-07-27	Prospective/conditional	CCPR; M. S. aka M. H. H. A. D.; 2601/2015. Articles 6(1), 7. According to the Committee’s operative finding, removal to Iraq would violate the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or sufficient individual risk assessment.	[328]
2017-07-28	Prospective/conditional	CCPR; Hibaq Said Hashi; 2470/2014. Article 7. According to the Committee’s operative finding, removal to Italy would violate the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or sufficient individual risk assessment.	[329]
2017-08-10	Prospective/conditional	CAT; G. I.; 625/2014. Article 3 (prospective). According to the Committee’s operative finding, removal to Pakistan would violate the stated Convention rights; Denmark must refrain from removal and ensure a fresh or sufficient individual risk assessment.	[330]
2017-11-07	Prospective/conditional	CCPR; O. A.; 2770/2016. Articles 7 and 24, separately and read in conjunction. Removal to Greece without steps to make a reasonable determination of age would violate Articles 7 and 24, separately and read in conjunction.	[331]
2018-01-25	Violation found	CRC; I. A. M.; 3/2016. Articles 3, 19. The operative section finds a violation of Articles 3 and 19 in a case concerning a girl’s protection against the risk of female genital cutting. Denmark is required to refrain from removal to Puntland; the finding does not document that cutting took place.	[332]
2018-03-26	Prospective/conditional	CCPR; C. L. and Z. L.; 2753/2016. Article 7. Removal to China would, according to the Committee's operative finding, violate the stated treaty rights; Denmark must refrain from removal and ensure a fresh or adequate individual risk assessment.	[333]
2018-07-13	Prospective/conditional	CCPR; Bayush Alemseged Araya; 2575/2015. Article 7. According to the Committee’s operative finding, removal to Italy would violate the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or sufficient individual risk assessment.	[334]
2018-07-16	Prospective/conditional	CCPR; K. H.; 2423/2014. Articles 6, 7. According to the Committee's operative findings, removal to Iran would be contrary to the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or adequate individual risk assessment.	[335]

Adopted	Finding category	Case, treaty provision and operative finding	Public original
2018-08-31	Violation found	CRPD; Iuliia Domina and Max Bendtsen; 39/2017. Article 5(1), (2) alone and read in conjunction with 23(1). Disability discrimination was found in a refusal of family reunification; Article 5(1) and (2), separately and read in conjunction with Article 23(1).	[336]
2018-12-13	Violation found	CERD; S. A.; 58/2016. Articles 5(d)(iii), 6. Established violation of Articles 5(d)(iii) and 6 in a case concerning racial discrimination and citizenship; insufficient compensation and the costs decision must be reconsidered.	[337]
2019-07-08	Prospective/conditional	CCPR; A. B. H.; 2603/2015. Article 7. According to the Committee's operative findings, removal to Afghanistan would be contrary to the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or adequate individual risk assessment.	[338]
2019-07-15	Prospective/conditional	CEDAW; R. S. A. A. et al; 86/2015. Article 2(d), (e), (f) read in conjunction with 1. Removal of the woman and her daughters to Jordan would violate Article 2(d), (e) and (f), read in conjunction with Article 1; requirement to reopen the asylum case and refrain from forcible removal.	[339]
2019-07-24	Prospective/conditional	CCPR; R. M. and F. M.; 2685/2015. Articles 6, 7. According to the Committee's operative findings, removal to Afghanistan would be contrary to the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or adequate individual risk assessment.	[340]
2019-07-25	Violation found	CCPR; Nimo Mohamed Aden and Liban Muhammed Hassan; 2531/2015. Articles 17, 23. Finding of unjustified interference with family life and a violation of Articles 17 and 23 in respect of Liban Muhammed Hassan. The wife's claim is not examined separately.	[341]
2020-09-28	Established and forward-looking	CRC; W. M. C.; 31/2017. Article 3; 6, 8 upon removal. Established violation of Article 3 in the handling of the children’s case; a return to China would additionally violate Articles 6 and 8.	[342]
2021-02-04	Violation found	CRC; R. H. M.; 83/2019. Articles 3, 19. The operative paragraph finds a violation of Articles 3 and 19 in a case concerning a girl's protection against the risk of female genital mutilation; requirement to refrain from removal to Somalia and ensure that she is not separated from her mother and brother.	[343]
2021-07-22	Prospective/conditional	CCPR; A. M. F. and A. M.; 2651/2015. Articles 6, 7. According to the Committee’s operative finding, removal to Ethiopia would violate the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or sufficient individual risk assessment.	[344]
2021-07-22	Prospective/conditional	CCPR; M. N.; 3188/2018. Articles 6, 7. Removal to Iran would, according to the Committee's operative finding, violate the stated treaty rights; Denmark must refrain from removal and ensure a fresh or adequate individual risk assessment.	[345]

Adopted	Finding category	Case, treaty provision and operative finding	Public original
2022-05-27	Violation found	CRC; S. S. F.; 96/2019. Articles 3, 19. The operative paragraph finds a violation of Articles 3 and 19 in a case concerning a girl's protection against the risk of female genital mutilation; requirement to abandon removal and avoid family separation.	[346]
2022-06-01	Violation found	CRC; H. K.; 99/2019. Articles 3, 6, 22, 37(a). The operative paragraph finds a violation of the girl's rights under articles 3, 6, 22 and 37(a); it requires reconsideration of the expulsion decision to India, with the child's best interests as a primary consideration.	[347]
2022-10-25	Violation found	CCPR; J. S. K. N.; 2754/2016. Article 26. Discrimination on grounds of disability was established in the handling of an application for naturalisation; article 26.	[348]
2022-12-01	Violation found	CERD; Momodou Jallow; 62/2018. Article 4(a) read in conjunction with 6. A lack of effective enforcement and investigation of racist hate speech was found; Article 4(a) read in conjunction with Article 6. Article 4(c) is not examined separately.	[349]
2023-03-16	Prospective/conditional	CCPR; Elezjana Elezaj; 2858/2016. Articles 6, 7. According to the Committee's operative findings, removal to Albania would be contrary to the stated Covenant rights; Denmark must refrain from removal and ensure a fresh or adequate individual risk assessment.	[350]
2023-05-16	Violation found	CRC; F. M. A. and H. K. A.; 140/2021. Articles 3, 19. The operative paragraph finds a violation of Articles 3 and 19 in a case concerning the risk of circumcision upon removal to Somalia; requirement to refrain from removal and prevent recurrence.	[351]
2023-08-25	Violation found	CRPD; Søren Mikkelsen; 61/2019. Articles 14 and 17 read with 25. Finding of a violation of Articles 14 and 17 read in conjunction with Article 25 in a case concerning coercive psychiatric intervention; requirement for an effective remedy, compensation and public acknowledgement.	[352]
2023-09-19	Violation found	CRC; O. M.; 145/2021. Articles 3, 9. Established violation of three children’s rights under Articles 3 and 9 in a family separation case; requirement to refrain from removing the father to Nigeria and reassess the case.	[353]
2024-05-24	Established and forward-looking	CRC; H. H.; 169/2021. Article 3; 19, 37(a) for the daughter upon removal. A failure to respect the child's best interests under article 3 was established; removal of the daughter to Somalia would additionally violate articles 19 and 37(a) because of the risk of female circumcision.	[354]

The separate F.K. decision of 2020-12-30 finds a serious breach of article 22 because Denmark disregarded the Committee against Torture's interim protective measure and removed F.K. to Turkey. At the same time, the new article 3 case on the merits is declared inadmissible. This is an established procedural breach outside the 57, not an additional favourable outcome on the merits or an additional unique person in relation to F.K. 580/2014. [355].

Follow-up must be assessed specifically:the Domina/Bendtsen disability-discrimination finding from 2018 remains. However, the Disability Committee’s later follow-up closes this very case with A (compliance),after Domina obtained permanent residence, legal costs were covered and the decision disseminated. This specific follow-up therefore cannot be used as evidence of continuing non-compliance in

The Domina / Bendtsen case. The local closure of the committee is not an effect measurement of all Danish family reunification cases. [356].

2.16 Other figures on scale excluded from the record total

The Refugee Appeals Board’s selected exact rows of favourable asylum findings yield 86 case outcomes in 2006 and 3.174 person-case outcomes in 2007–2015 and 2021–2025, including the specified separate reopening rows. Added to this are 349 remittals in spontaneous asylum cases in 2022–2025. A favourable asylum finding shows a favourable review decision; the specific original violation and its consequence must be substantiated in the original sequence of events. The change in unit between cases and person-cases, and the missing exact years 2016–2020, are retained. The rows are therefore not included in the aggregate total of adverse/corrective entries above.

The Refugee Appeals Board’s separate review rows

Year or period	Number	Outcome category	Counting unit	Source
2006	86	Finding in the applicant's favour in a new/spontaneous asylum case	Outcome	[357]
2007	68	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[358]
2008	156	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[359]
2009	71	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[360]
2010	269	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[361]
2011	407	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[362]
2012	370	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[363]
2013	413	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[364]
2014	236	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[365]
2015	212	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[366]
2021	64	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[367]
2022	130	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[368]
2023	144	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[369]
2024	102	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[370]
2025	97	Finding in the applicant's favour in a new/spontaneous asylum case	Individual case outcomes	[371]
2009	60	Finding in the applicant's favour in a reopened asylum case	Individual case outcomes	[360]
2010	11	Finding in the applicant's favour in a reopened asylum case	Individual case outcomes	[361]
2012	42	Finding in the applicant's favour in a reopened asylum case	Individual case outcomes	[363]
2013	132	Finding in the applicant's favour in a reopened asylum case	Individual case outcomes	[364]
2014	53	Finding in the applicant's favour in a reopened asylum case	Individual case outcomes	[365]
2015	71	Finding in the applicant's favour in a reopened asylum case	Individual case outcomes	[366]
2021	66	Finding in the applicant's favour in a reopened asylum case	Individual case outcomes	[367]
2022	91	Remittal in a spontaneous asylum case	Individual case outcomes	[368]
2023	110	Remittal in a spontaneous asylum case	Individual case outcomes	[369]
2024	49	Remittal in a spontaneous asylum case	Individual case outcomes	[370]
2025	99	Remittal in a spontaneous asylum case	Individual case outcomes	[371]

Patienterstatningen's injury acceptances

Year or period	Number	Counting unit	Source
2006	1.482	decisions recognising treatment injuries	[372]
2007	1.488	decisions recognising treatment injuries	[372]
2008	1.506	decisions recognising treatment injuries	[372]
2009	2.379	decisions recognising treatment injuries	[372]
2010	2.518	decisions recognising treatment injuries	[372]
2011	2.712	decisions recognising treatment injuries	[372]
2012	2.783	decisions recognising treatment injuries	[373]
2013	3.055	decisions recognising treatment injuries	[374]
2014	2.865	decisions recognising treatment injuries	[374]
2015	2.627	decisions recognising treatment injuries	[374]
2016	2.670	decisions recognising treatment injuries	[374]
2017	2.513	decisions recognising treatment injuries	[375]
2018	2.226	decisions recognising treatment injuries	[375]
2019	2.232	decisions recognising treatment injuries	[375]
2020	2.122	decisions recognising treatment injuries	[375]
2021	2.370	decisions recognising treatment injuries	[91]
2022	2.067	decisions recognising treatment injuries	[91]
2023	2.791	decisions recognising treatment injuries	[91]
2024	2.810	decisions recognising treatment injuries	[91]
2025	3.482	decisions recognising treatment injuries	[91]

Patienterstatningen's selected treatment-injury decisions for 2006–2025 sum to 48.698 acceptances. These are decisions on injury and the basis for compensation, not an automatic count of unlawful acts by authorities. An accepted injury may feature in a healthcare complaint, and one person may have several injury decisions. The separate sum has therefore not been added to 202.870. Reports of adverse events are likewise not counted as established legal violations; the reporting scheme's units, selection and batch reporting have changed over time.

2.17 Cases not appealed, actual lawfulness and the remaining count

Annual complaint records show only what reaches the oversight system and receives the outcome in question. They do not cover all original decisions, all citizens who give up, corrections before referral, coercion that actually continues, waiting time or harm after a complaint is upheld. The specific practice studies and national case samples therefore examine a different part of the problem and are shown separately. Different error types in the same case sample may concern the same case; the published total number with at least one error is used where available, and error-type columns are not added together uncritically.

Rigsrevisionen’s 2026 report on first placements in 2022–2024 identifies at least one measured breach of law in 69 percent of 3.148 case histories. This is a rounded percentage; multiplying 69 percent by 3.148 does not produce a published exact count. The 77 Copenhagen cases in 2017 with at least one deficient safeguard, and the delimited practice samples in child, disability and employment cases, are therefore excluded from the annual-record total where overlap has not been reconciled. They have independent evidential value concerning actual practice. [112].

The 2026 follow-up is not counted as an additional completed calendar year in the main period. It shows which earlier problems still require specific redress and oversight. A final national count of distinct violations requires linkage between the event, decision, grounds of error, individual, authority, later review and actual redress. The demand on the state is to disclose this linkage and the missing years and raw figures. The absence of such a public aggregate count does not negate any of the documented oversight findings.

The historical child welfare surveys below find at least 361 case instances containing errors among 571. In 2009, two tables give 104 and 105 respectively; 104 is used, and the difference of one case is retained. If this sample is omitted entirely, 257 instances containing errors remain among 446 in the other four. In the 2011 moving/return-home survey, the denominator 81 used consistently in the analysis is used, although the description of cases received minus cases excluded gives 82. These specific discrepancies in the sources do not change the documented errors in the other cases. Decision windows may overlap between surveys; the count is of case instances in review samples, not a union of distinct children.

Verification publication	Error/verification findings / examined	Decision-date window	Precise definition of the finding	Source
2006	23 / 101	01.01.2006–20.04.2006	78 correct, 23 incorrect	[16]
2008	92 / 143	01.01.2006–15.05.2007	51 correct; 3 without basis + 21 without voluntary consent + 68 other formal deficiencies = 92	[17]
2009	104 / 125	Latest decisions before 01.01.2009; individual starting date not established	Table 2.2 shows 104, Table 2.5 and the text 105. Conservatively 104 as lower control findings; difference in one case unresolved.	[18]
2011	75 / 121	Latest decisions before 01.02.2010; individual starting date not established	46 correct; 25/43 respite care + 25/33 contact person + 25/45 placement = 75	[29]
2011	67 / 81	01.2010–03.2011	40/50 moves +27/31 returns home =67. The report’s 132 submitted minus 50 excluded is 82,but the consistently analysed n is 81; difference noted.	[26]

The Child Welfare Case Barometers are not complaint statistics. They examine cases that have not been appealed and have different denominators for the individual statutory requirements. The five publications for 2020–2024 contain 3.629 case instances and 4.459 requirement-specific error registrations concerning the five safeguards below. The largest error category in each sample provides a reliable minimum of 322 + 273 + 309 + 294 + 248 = 1.446 case instances containing errors. This minimum is not the published total number of cases with at least one error and not a deduplicated

union of individuals. In particular, the decision windows for 2020–2022 overlap. The consolidated report for 2020–2022 is not added as a sixth measurement.

The distribution of the 4.459 specific deficiencies in safeguards is 1.006 missing or inadequate child welfare assessments, 945 failures to meet the assessment deadline, 1.446 missing interviews with children before the decision, 647 missing or inadequate action plans and 415 missing or delayed first follow-ups. Lawful exceptions have been deducted from the original numerators used. One case occurrence may contain several deficiencies. Each individual failure of a safeguard therefore retains its legal significance, without inventing a number of distinct children.

Publication year	Errors / denominator for the requirement	The statutory requirement checked	Source and decision period
2020	215 / 731	Child welfare assessment missing or insufficient	[376]
2020	219 / 330	Four-month deadline for examination exceeded	[376]
2020	322 / 717	Children's interview before the decision is missing	[376]
2020	152 / 735	Action plan missing or insufficient	[376]
2020	58 / 118	First follow-up after three months missing / too late	[376]
2021	187 / 692	Child welfare assessment missing or insufficient	[20]
2021	146 / 367	Four-month deadline for examination exceeded	[20]
2021	273 / 699	Children's interview before the decision is missing	[20]
2021	87 / 708	Action plan missing or insufficient	[20]
2021	49 / 87	First follow-up after three months missing / too late	[20]
2022	252 / 687	Child welfare assessment missing or insufficient	[21]
2022	185 / 284	Four-month deadline for examination exceeded	[21]
2022	309 / 691	Children's interview before the decision is missing	[21]
2022	161 / 697	Action plan missing or insufficient	[21]
2022	46 / 102	First follow-up after three months missing / too late	[21]
2023	209 / 744	Child welfare assessment missing or insufficient	[22]
2023	208 / 314	Four-month deadline for examination exceeded	[22]
2023	294 / 746	Children's interview before the decision is missing	[22]
2023	127 / 765	Action plan missing or insufficient	[22]
2023	144 / 475	First follow-up after three months missing / too late	[22]
2024	143 / 709	Child welfare assessment missing or insufficient	[23]
2024	187 / 371	Four-month deadline for examination exceeded	[23]
2024	248 / 708	Children's interview before the decision is missing	[23]
2024	120 / 724	Action plan missing or insufficient	[23]
2024	118 / 473	First follow-up after three months missing / too late	[23]

Publication	Verified decision period	Case occurrences	Error registrations across five requirements	Minimum number of case instances with errors
2020	25.03.2016–25.03.2019	735	966	322
2021	08.01.2017–08.01.2020	708	742	273
2022	11.03.2017–11.03.2020	697	953	309
2023	Decisions 2021,case processing 2020–2021	765	982	294
2024	Decisions 2022, case processing 2021–2022	724	816	248
Total	Five samples, partially overlapping time windows	3.629	4.459	1.446

The 2019 pilot survey is kept separate: at least 99 of 228 case instances examined have a measured deficiency, because the child interview is missing in 99 of the 226 relevant cases. The sample concerns 07.11.2015–07.11.2018. The other requirement columns are not additional unique cases. [377].

Eight further social services and employment studies record 196 reviewed instances that were substantively incorrect or warranted alteration or remittal out of 803 examined: 39 + 17 + 42 + 16 + 4 + 30 + 17 + 31. The definition follows each sample. In studies of pension and flexible employment awards, the findings cannot be relabelled as unlawful refusals. They show errors concerning lawfulness and the basis for decisions, with their respective consequences. All eight original methodology sections have been checked. Four contain a complete decision window, while the sickness benefit studies, the dementia study and the 2019 pension study have a verified cut-off date or different sampling rules without a published common date boundary. These specific gaps are shown in each row. The year in which the review was published is therefore recorded separately and is not converted into the year of the event.

Verification publication	Error/verification findings / examined	Decision-date window	Precise definition of the finding	Source
2015	39 / 125	Latest decisions made before 15.04.2015 under expanded submission criteria; no common earliest decision date is fixed in the methodology section.	39 substantively incorrect; 26/22 concerning the medical basis are error themes within the same sample and are not added to the total	[32]; [32]
2015	17 / 102	First contact after 01.01.2014; eligibility-assessment period completed before 01.06.2014. Most recent assessments working backwards from the cut-off date.	17 incorrect; interview, information and medical subthemes overlap	[30]; [30]

Verification publication	Error/verification findings / examined	Decision-date window	Precise definition of the finding	Source
2016	42 / 130	11.05.2013–16.06.2015, actual decision dates.	42 substantively incorrect awards; must not be reformulated as 42 unlawful refusals	[25]; [25]
2015	16 / 78	01.10.2013–01.04.2014.	16 substantively incorrect awards	[27]; [27]
2019	4 / 100	Decisions not until 01.10.2017; latest cases. No single upper decision date has been published in the controlled methodological annex.	4 substantively incorrect; long waiting times in separate cases do not add to the union of cases	[28]; [378]
2015	30 / 57	Most recent decisions before 31.12.2014, then backwards; no common earliest decision date fixed in the request for submissions.	30 incorrect/non-compliant with rules; 6/7 detentions and 21/34 late registrations are not additional unique cases	[31]; [379]
2016	17 / 115	First 12 municipalities: last ten decisions before 01.07.2015, called 11.08.2015. Four additional municipalities: Call letter 16.09.2015; end September also decisions after 30.06.2015 but before the call were accepted. No joint lower decision date published.	17 would be overturned on determination on the merits	[380]; [380]
2024	31 / 96	01.06.2022–15.04.2023.	28 amendments + 3 remittals = 31	[381]; [382]

The Citizens' Adviser's Copenhagen investigation in 2017 finds errors or deficiencies in all 77 cases examined from 2013–2016. The specific deficiencies in safeguards are subsets of the 77 and are not added as extra cases.

Verification publication	Error/verification findings / examined	Decision-date window	Precise definition of the finding	Source
2017	77 / 77	2013–2016	All 77 have at least one error/deficiency; deficiencies in hearing the parties, consent, guidance and competence are subsets	[84]

Seniorpensionsenheden has a separate series outside the municipal series. In 2024 there are 46 amended/annulled and 241 remitted outcomes, i.e. 287 overturnings among 1.138 substantively determined

appeal cases. 170 cases have formal errors; 76 of them have already been remitted and 43 already amended. Only the 51 upheld decisions with formal errors constitute additional entries in a local union: 287 + 51 = 338 outcomes involving overturning or formal error. Adding 287 and 170 would double-count 119. This locally reconciled oversight finding is not subsequently included in the gross total of 202.870. [383].

3 Denmark’s documented knowledge and the failure to resolve the problems

3.1 Knowledge is a chain of responsibility

The conclusion is that institutional knowledge of the problem was repeated and concrete. It can be documented through published practice studies, the authorities' own responses, ministerial interventions, international investigations and concrete complaints. These documents have different recipients and different functions of proof. The report does not require any employee to have read all national reports personally before the institution's responsibilities can be investigated. Personal guilt, on the other hand, requires a precise chain of actors.

For each warning, the following chain must be established: first identified finding → sender → competent recipient → date of receipt → available action → actual decision → follow-up verification → the affected citizens’ continuing or restored circumstances. Publication demonstrates public knowledge of the problem. A government response, a received Task Force memorandum or an internal email is stronger evidence of particular bodies’ knowledge. Such links must support the allegation of responsibility after a warning.

3.2 Chronology with different types of documentation

2006. The Appeals Board’s placement survey assessed 23 of 101 decisions examined as incorrect. The sample came from 20 municipalities; cases already appealed were excluded. The survey documented, among other things, the absence of current assessments. Police summaries from the same year described unnecessary and humiliating use of force and incorrect attribution of the authorship of interrogation reports. This provides both early knowledge of child-rights problems and specific leads concerning integrity and responsibility. [16]; [98].

2007. The police's disciplinary material described, among other things, a citizen who left the police without having his report of violence recorded and an unwarranted arrest in a private conflict. The public function was thus used or omitted in ways that directly affected the protection of the citizen. The summaries shall be linked to original complaints and investigations; they shall not be reproduced as convention judgments. [99].

2008. A new placement investigation found 92 incorrect decisions among 143. In 22 cases, the necessary consent was actually absent according to the investigation’s count. The CPT simultaneously described non-compliance with safeguards for people in custody despite their having existed for several years, and inadequate follow-up on prolonged psychiatric restraint. This documents new findings after earlier warnings, rather than merely reproducing the material from 2006. [17]; [39].

2009. The placement survey contained an internal source conflict: 104 and 105 incorrect decisions respectively among 125. The conflict must be retained. The assessment now also included a time limit, which limits direct comparison with previous years’ error rates. The recurring legal failures nevertheless remain: assessment, consent and a basis in planning failed in a new sample. [18].

2010. The Ombudsman established the unlawful record-keeping practice and the central health authorities’ acceptance over many years. Material from Datatilsynet described a public authority’s failure to comply with a recommendation from 2005. This provides two specific historical chains of knowledge. One concerns exemption from liability; the other concerns five years without follow-up on a record-keeping and security problem. [67]; [48].

2011. The involvement survey found 75 incorrect decisions among 121. The moving and return-home survey found 67 incorrect decisions among 81. Consent, child interviews, action plans and the return-home process were central problems. The UN Committee on the Rights of the Child criticised insufficient municipal registration, support and follow-up and placed children without individual plans. There was therefore national and international knowledge of problems in the same area of rights. [29]; [26]; [60].

2012. The Tibet interventions show another form of knowledge: operational orders, briefings and actual implementation. The CPT's visit to Greenland led to urgent representations concerning a minor in police custody and vulnerable women deprived of their liberty. A later investigation of foster children in Copenhagen also covered circumstances from 2011-2012. The sources for this period must therefore be distinguished by incident, investigation and the time at which management acquired knowledge. [126]; [127]; [41]; [84].

2013. The Government's response to the CPT acknowledged deficiencies in reliable information on solitary confinement and missed visits in Greenland and maintained a monitoring arrangement for restraint that differed from the CPT's recommendation. The UN Economic and Social Committee called for protection and support for several vulnerable groups. The National Tax Tribunal's own report documented a growing backlog and exceeded time targets. In these areas, a response to criticism did not certify effectiveness. [40]; [63]; [86].

2014. The CPT continued to find inadequate follow-up concerning, among other things, restrictions on contact and prolonged restraint. The State established an interministerial human rights committee for recommendations and follow-up. Its establishment documents an organised channel for acquiring knowledge. Its impact must be tested against subsequent findings, meeting materials, responsible ministries and follow-up decisions. [42]; [43].

2015. Practice studies documented significant deficiencies in medical information, assessment and follow-up in the employment field. The dementia study found 30 assessments calling for amendment or remittal among 57 case entries. The police summary described a helpless person with Parkinson’s who was found after more than 42 hours without the rescue effort that his call had given reason to consider. These are different areas of protection with different duties. [32]; [31]; [102].

2016. The instruction case documents an unlawful scheme for separating asylum-seeking couples. The change to the instruction on 18. March did not automatically end the separations already carried out; reopening for the purpose of hearing the parties followed on 28. April. This difference of 41 days is a concrete illustration that correcting a rule and providing redress to the citizen are different events. [104]; [65].

2017. Copenhagen's investigation found at least one of the deficiencies examined in the files of all 77 children. Earlier problems with municipal supervision and record-keeping had already been described. The documented requirement is to verify afterwards whether the specific errors were corrected and whether the rights of children and parents were restored. An assumption that errors had been or would be corrected is insufficient evidence for closing the matter. [84].

2018. The Ombudsman's investigation FOB 2018-33 found that a revised action plan and a prior interview with the child were missing in all four selected cases of children returning home in one municipality. This shows that scrutiny must also cover the ending of an intervention. Returning a child home is not a legal exemption from the child's participation and support. [68].

2019. The pilot legal-compliance barometer examined 228 cases that had not been appealed from 12 municipalities and found specific deficiencies concerning current assessments, deadlines and interviews. The CPT described a lack of progress on key police safeguards since 2014 and unacceptable conditions of deprivation of liberty. The UN Economic and Social Committee called for an impact assessment of the pension and flex-job reform. These sources connect already known problems with new scrutiny findings. [24]; [44]; [64].

2020. The Task Force material from Nordfyn and Faaborg-Midtfyn contains management statements concerning financial governance, delayed assistance and the risk that ineffective measures would continue. The mink case creates a separate line of inquiry concerning instructions, legal authority and public communication. Management statements must be linked to governance documents and the specific cases affected; they already constitute evidence that the statements concerning those problems were made. [124]; [125]; [72].

2021. Rigsretten's judgment established an intentional breach of ministerial duties in the instruction case. The UN material reiterated, among other things, demands for data and protection against discrimination and violence. A criminal conviction in a particular ministerial case does not close the other sectors' chains of responsibility or prove full redress for each family. [104]; [65].

2022. Tibetkommission II changed substantial parts of the earlier official explanation on the basis of new material. Minkkommissionen published its findings within its mandate. This documents why an initial official narrative must not become an untested endpoint. Original email archives, search methods and disclosure processes may be decisive for responsibility. [127]; [72].

2023. The Task Force findings in Langeland showed continuing safeguard deficiencies and doubt about sufficient support. The Committee against Torture criticised the scope of police-complaint investigations and the small number of criminal charges. The national and international warnings concern different cases, but both point to the need to clarify the incident, protection and responsibility beyond a registered closure. [123]; [76]; [66].

2024. The Child Case Barometer again published significant deficiencies, this time in selected decisions and trajectories from 2021-2022. CPT recorded repeated coercive interventions against young people and adults and called for oversight. The Disability Committee's criticism provided a specific track concerning insufficient support for parents with disabilities. The respondent survey of social workers provided a specific lead concerning finances and management wishes. [47]; [23]; [45]; [62].

2025. Rigsrevisionen’s oversight report showed deficient enforcement and follow-up in the material from 2018-2024. The follow-up on child psychiatry showed continuing capacity-related delays. The Tibet judgments concerned false statements in 2013 and followed a very lengthy chain of accountability. The psychiatric appeal figures showed interventions set aside, procedural unlawfulness and periods of restraint set aside. [106]; [109]; [51]; [127]; [132].

2026 supplement. The placement report examined 2022-2024 processes. The ministry required renewed supervision in Langeland. The police reports examined 2019 to the first half of 2025,and the minister issued statements in September 2026. These statements contain specific measures and future deliverables. They are not documentation that previously affected individuals have received redress or that the risk has already been permanently removed. [112]; [110]; [111]; [78]; [81]; [79]; [76].

3.3 What the chronology supports

The chronology supports a serious accusation concerning the authorities’ governance and oversight: the same kinds of legal safeguards have failed in new cases after repeated investigations and warnings. Children’s services provide a particularly clear chain from the early practice investigations through the pilot legal-compliance barometer, later barometers and Rigsrevisionen’s investigation. Other sectors document their own patterns of duration and recurrence. They must not be forced into an assertion of precisely the same mechanism in every case.

Nor is this controlled evidence that raw error rates rose monotonically every year. Criteria and samples changed. The sustainable conclusion is persistent, repeated serious deficiencies following documented knowledge of the problem and insufficiently documented lasting remedial action. This is in itself a strong criticism of the authorities. It requires an answer about the specific duties and results, not a general list of new initiatives.

4 Improvements must be tested on their actual effect

4.1 A completed project does not mean a violation of rights has ceased

Conclusion: The authorities' claims of improvement must be assessed by their documented effect on the error and the group of individuals that the initiative was intended to protect. Evidence: Langeland's staffing increases and organisational changes did not provide a sufficient basis in terms of legality for closing supervision; the 2026 ministerial statement required a fresh examination. Significance: an activity can be real without documenting the claimed remedy. Rule: the investigative principle, supervisory review of legality and the specific protective duties. Omission: failure to verify lawful practice and follow up affected cases. Departure: closing oversight on an insufficient factual basis. Consequence: continuing risk and undocumented redress. Responsibility: municipality, professional management and supervisory authority according to each actor's knowledge and jurisdiction. Demand: case-by-case results and independent follow-up verification.

4.2 Three levels of documentation for reform

An activity entry shows that a plan has been made, training delivered or staff employed. A practice entry shows whether statutory acts are actually carried out correctly and in time in the cases. An individual-focused outcome measure shows whether people receive the assistance and protection to which they are entitled, whether interventions end and whether the error's consequences are remedied. All three may be relevant, but cannot replace one another.

An authority that documents only the first level and then declares the problem solved draws a conclusion without the necessary evidence of effect. When subsequent review finds the same failures of safeguards, this is independent evidence that the previous closure of oversight did not provide sufficient protection against recurrence. Where the material merely lacks outcome data, the conclusion is absence of documented effect. Where later findings directly show continuing errors, the conclusion is documented insufficient remedial action in the practice examined.

4.3 The specific test of lasting improvement

Improvement must be linked to the original error, a comparable baseline and a clearly delimited population. It must include lawfulness, timeliness and actual effect. A lower published error rate may result from new criteria, exclusion of appealed cases, changed registration, fewer assessments or omission of long unfinished courses. These circumstances must be reconciled before the result is called an improvement.

A safeguard against recurrence must also show who owns the follow-up, how new incidents are detected, how an affected citizen is promptly protected, and what action non-compliance triggers. Lasting improvement here means a documented, stable practice with an oversight safeguard that continues to function. No bounded period of observation can prove that an error will never recur. Oversight must therefore continue according to the level of risk and the legal duty; permanent improvement must not mean a permanent absence of supervision.

4.4 Changing targets as an example of a misleading picture of improvement

The Appeals Board's change of the administrative time target from 13 to 30 weeks must be registered as a change of target. It must not be registered as an actual reduction in waiting time. An institution's fulfilment of a more lenient management target proves neither compliance with a statutory time limit nor a reasonable time under the Convention. A child, patient or citizen without subsistence support may need protection long before the management target's endpoint. [105]; [37].

In the tax area, the 2013 report's target attainment showed a points calculation, not the proportion of citizens dealt with within the time limit. Certain time measures began only when the case had been fully investigated, and periods when cases were put on hold were excluded. An officially satisfactory or improved target score can therefore coexist with a long actual waiting time. The criticism demands publication of the citizen's entire course, including periods on hold and the time after a finding in the party's favour. [86].

4.5 The police's September statements must form part of the review

The minister's statement of 14. September 2026 reports, among other things, ending the use of the inquiry-case classification for potential criminal cases, stronger registration, investigative analysis and more resources. The statement says that the full effect of the general strengthening is not expected until towards the end of the agreement period. This documents the state's current measures and expectations. It does not document their final effect for individuals. ([78])

The implementation appendix calls an initiative completed when its deliverables have predominantly been implemented and put into operational use. This is a definition based on delivery. It does not define the cessation of failures to protect or redress for victims. The supplementary statement of 28. September specifically addresses criticism of missing authorisation and resource-based discontinuances. A subsequent examination of actual recording, investigation, reconsideration and protection must therefore be demanded. ([81]; [79])

4.6 Actual partial results may not be sold as full redress

The CPT's local figures show, for example, fewer recorded restraint incidents in Aarhus in 2023 than in 2022. The same material continues to show very prolonged interventions and repeated interventions involving young people. The observed decrease must be acknowledged for what was measured, and then examined in terms of duration, discontinuities in recording, patient population and substitute interventions. A partial decrease does not prove full lawfulness or lasting elimination of risk. [39]; [42]; [44]; [45]; [46].

In De retsløse, Mohammad is described as having been granted BPA in 2023 and subsequently living a more independent life. The account must preserve this factual turning point. It does not change the question of the earlier lack of assistance or responsibility for it. Strong criticism follows both the earlier harm and the later correction; otherwise it cannot distinguish between a remedied problem and an unresolved problem. ([2], pp. 29-31)

5 Immunity, liability exemption and risk retention

5.1 The strongest valid immunity criticism

The strongest sustainable conclusion is that certain legal and administrative mechanisms can protect public actors from personal consequences and thus allow risk to continue. The unlawful record-keeping practice shows an actual institutional exemption from responsibility. Police disciplinary cases show weakened accountability after delay. The supervisory material shows a weak enforcement link in the population examined. These lines of evidence must be combined as different mechanisms; none must be erased by a general reference to personal responsibility existing in law.

In this analysis, de facto immunity means documented practical protection from relevant consequences of responsibility. It must always be followed by the name of the mechanism: unlawful exemption practices, lapse caused by delay, limited recourse, inadequate investigation or a specific statutory exception. Lack of public data alone is a transparency deficiency. It does not automatically prove that no sanction was imposed.

5.2 Unlawful exemption from liability in healthcare administration

Conclusion: A practice followed by the authorities may unlawfully have conferred exemption from liability in an area where the law imposed a duty on the professional. The authorities' position: in the situation described, medical recordkeeping was in practice treated as secretarial work, and the hospital doctor was generally not held responsible. Original evidence: the Ombudsman's investigation from 2010, including acceptance by central authorities over twenty years. Deficiency: statutory responsibility was shifted through administrative practice. Rule: the recordkeeping duty in force at the time and the correct basis for examining the complaint. Action: an accepted and applied practice of exemption. Departure from the law: the Ombudsman's finding of unlawfulness. Significance: patients could have their claims concerning responsibility examined on an incorrect basis. Responsibility: the board, health authorities and ministry according to their documented roles. Remedy sought: identify the decisions concerned, subsequent correction and reconsideration.

The specific evidence changes the strength of the immunity issue. This is more than a suspicion of reluctance to impose sanctions. There is a documented administrative law problem of exemption from accountability that central authorities knew of and accepted. The number of affected patients, losses and subsequent redress are separate evidential tasks. The illegality already established stands while these tasks are addressed.

5.3 Personal financial liability and employer's bill

Section 23 of the Liability for Damages Act limits, on grounds of reasonableness, the employer’s recourse against the employee and may limit the employee’s direct liability. Culpability, position and other circumstances are taken into account. The rule also applies to private employment. It does not abolish employer liability or criminal liability. Its relevance here is that the citizen’s compensation and the individual decision-maker’s financial consequences do not necessarily coincide. ([58])

The specific question is therefore who actually paid, whether recourse was considered and what reasons were given. An institution may pay for an error without investigating the management instruction or the responsible manager’s continued performance of duties. This may weaken protection against recurrence. The existence of this mechanism is a legal finding. That it kept a particular violator in post in a particular case must be documented in the actual personnel and responsibility records.

5.4 A separate limitation of the punishment of authorities as legal persons

§ 27, subsection 2, of the Criminal Code limits the criminal liability of state authorities and municipalities as legal persons to offences committed in activities corresponding to, or comparable to, private activities. This is a further aspect of the framework of responsibility: ordinary exercise of public authority may fall outside this organisational criminal liability, while employees' personal liability and the state's other responsibilities must be examined separately. The availability of fines against legal persons must therefore not be assumed to provide a general safeguard against errors in the exercise of public power. ([118]; § 27)

The question must be asked which accountability track actually covers the documented authority act when organisational punishment is limited, individual culpability is not yet clarified, and an administrative response does not secure cessation. A gap between these tracks is a specific investigation and reform problem. It is not legal permission to violate the individual’s rights.

5.5 Reporting for learning and responsibility on another basis

The Health Act’s protection of reporting adverse incidents must be distinguished from responsibility for the act itself. The statutory text indicates the scope of section 201 and the need for independent records, logs and witness evidence. A learning scheme can specifically protect the basis for reporting. It does not prove that every serious failure is exempt from liability on every evidential basis. [121].

The demand is a clear, lawful separation of learning from incidents, the individual’s access to evidence, immediate protection and relevant accountability on an independent basis. An authority must not use the word learning as a complete justification for failing to examine documented risk, serious breaches of duty or redress. The specific statutory rule and its data basis must be shown.

5.6 A specific statutory exception in Greenland’s compensation case

The text of the 2026 Compensation Act identifies an express exception for authorities and their employees from a specific fine for failure to fulfil a duty to provide information. This is a specific legal difference in responsibility and must be stated. It must not be expanded into general immunity for historical contraceptive interventions or other duties. [88].

The strongest question is how a reparations scheme secures individuals’ access to information when public actors specifically are exempt from the stated fine provision. The examination must cover alternatives to compelled provision of information, completeness of archive material, retrieval, case-processing time and actual payment. A compensation scheme is not in itself proof that everyone affected has been able to pursue their claim.

5.7 When liability lapses through the Authority's own delay

Conclusion: Documented delays in accountability may provide practical protection for the person originally responsible. Statement and evidence: the police summaries describe proceedings lasting almost four years that affected the response, and disciplinary proceedings that were not instituted following a late recommendation despite conduct that was relevant to disciplinary action and wholly unacceptable. Deficiency: timely accountability was not secured. Rule: the specific disciplinary procedural rules and relevant duties to investigate. Omission: delayed case processing or recommendation. Significance: a weakened response or none at all. Responsibility: both the original actor and those responsible for the delay must be identified. Demand: a dated procedural chronology, monitoring of deadlines, preservation of evidence and a separate decision on responsibility for the delay.

Tibetkommission II likewise described possible criminal responsibility as time-barred and disciplinary responsibility as impeded by time and departures. Limitation must be calculated according to the specific provision and interruption. That a criminal case is time-barred is not a finding that the original act was lawful. The

Nor must the public follow-up chain erase this fact from the historical assessment of responsibility. [126]; [127].

Sentencing in the Tibet case also shows a specific protective effect of time: the District Court's published reasons state that giving false evidence in court usually results in 60 days of immediate imprisonment. Here, it reduced the sentence to 30 days and suspended it, referring to more than ten years since the statements, more than five years since the indictment, and transfer and suspension from duty. This documents a weakened penal response in the specific sequence of events; it does not prove that suspension never took place. The accountability investigation must trace who created the time intervals. [85]. The later High Court decision is identified separately: [132].

5.8 Retaining repeat violators of legal safeguards

Serial recurrence must be documented at actor level:the same employee or manager, separate incidents, an identified breach of duty, knowledge after the first incident, the subsequent action and continued performance of duties. Several cases in the same municipality document institutional recurrence; they do not automatically identify the same employee. The 2006 police material expressly links two entries concerning the same employee, showing that specific person linkage may be found in the material. That link must still be read alongside each entry's actual action and final outcome. [98]; [99].

Once this chain is documented, the report must be able to ask the direct question: why was the person still placed in a position enabling the same violations to recur, and who approved this? Where a serious specific risk exists, protecting citizens is a separate issue that must not await a final criminal judgment. Relevant temporary changes in duties, supervision and powers of intervention must be assessed on a lawful basis and against the actual risk. Reassignment that transfers the same risk to other citizens does not demonstrate redress.

In the Article 3 field, the Gäfgen judgment shows that a symbolic penalty and subsequent appointment to head the police technology, logistics and administration department can be insufficient responses to serious ill-treatment. The judgment's requirements cannot be applied mechanically to every administrative error. Its central significance is that a recorded sanction must be examined for seriousness, deterrence and safeguards against recurrence. ([55]; paragraphs 123-125)

5.9 Obedience to management and the risk of speaking up

Responses to the social-worker survey connect decisions experienced as unlawful with finances and senior management's wishes. The police reports provide similar leads to organisational priorities. This supports intensified investigation of whether management made unlawful practice an expected work task. ([110]; [111]; [47])

To document the asymmetry of responsibility and incentives in an individual course, specific employees who followed the criticised instruction must be compared with specific employees who raised professional or legal objections. Was there a warning, notice of intended dismissal, changed duties, a worse assessment or another employment consequence for resistance? What personal consequence affected those who implemented the documented unlawfulness? Without such records, the asymmetry is a strongly grounded hypothesis about incentives, not a measured national fact.

Instructions must be secured in their original form. A manager's order does not in itself establish lawfulness. Section 156 of the Criminal Code refers to a lawful official order; it does not provide a general exemption for executing unlawful orders. Complicity and management's own duties must be examined according to specific conduct and culpability. Where repeated professional warnings were disregarded, the manager's continuation of the practice is itself an independent line of accountability. [118]; [104].

5.10 The official obedience rule reveals a specific asymmetry in accountability

Conclusion: Responsibility must be traced to management when an order that has been maintained is followed without individual liability on the part of the person carrying it out. Original evidence: the joint guidance from 2017 describes a duty to raise concerns in cases of doubt, compliance with a maintained order that is not clearly unlawful, and a duty to refuse a clearly unlawful or criminal order. It states that, in the first situation, the person carrying out the order incurs neither employment-related nor criminal liability even if the order later proves unlawful; the authority's responsibility remains. Refusal may, in principle, constitute a disciplinary offence. This is a documented structure of rules, not a measure of actual dismissals.

Significance, departure and responsibility: when management receives a specific warning and maintains the order, the warning, decision and consequences for the citizen must be secured. If scrutiny subsequently examines only the executor’s culpability, management’s decision may escape review. Demands: separate scrutiny of management and documentation of the employee’s opportunity to lawfully refuse. No rule for resolving uncertainty legalises the authority’s unlawful act.

5.11 Lawful criticism was met with documented negative management responses

Conclusion: Obstruction of lawful professional speech is a documented oversight problem. In FOB 2019-2, the Ombudsman found that four employees had been summoned to meetings following lawful statements; several expressed regret for their statements. A fifth received a written warning on an inadequately reasoned basis. The overall handling was described as highly criticisable. The municipality stated that guidance was being prepared. This documents the response and the announced communication of guidance, not a verified lasting change in practice.

FOB 2026-4 examined a specific sequence of events in 2025: a teacher was reprimanded after a newspaper interview and encouraged to keep a low profile with the press. The municipality described the conversation as guidance without a disciplinary sanction. The Ombudsman found the handling worthy of criticism and the encouragement mentioned clearly contrary to the rules. A general discussion and a letter had not sufficiently corrected matters. The published follow-up reports subsequent reopening, a conversation, an apology and the municipality’s confirmation that there were no adverse employment-law consequences. The criticism concerns the documented response and the inadequate initial correction; the subsequent specific remedy is retained. [135].

Rule: From 1. July 2025, the Act on Public Employees’ Freedom of Expression prohibits adverse employment measures and obstruction of statements made on employees’ own behalf within the Act’s conditions. Earlier events are examined under the law applicable at the time. [384]. Protection under the Whistleblower Act requires, among other things, a report within its scope and reasonable grounds to believe that the information is correct. § 8 prohibits retaliation; §§ 28-29 govern compensation, possible reinstatement and the employer’s burden of proof once a report within the Act’s scope and a detriment have been proved. Ordinary professional disagreement does not automatically entail all these legal consequences. [385].

Act, departure, consequence, responsibility and demands: The specific minutes and letters must be compared with the lawful expression, the employment consequence and the correction. Management’s response may make future warnings less likely and weaken protection of individuals; the causal link in a particular individual’s case must be shown separately. The demand is correction of the personnel case, specific protection of lawful criticism and examination of the responsible managers’ actions. The official label of guidance cannot replace examination of the response’s actual content.

6 Positive obligations, human rights and international-law responsibility

6.1 Right by right and duty by duty

ECHR Article 1 requires Denmark to secure Convention rights within its jurisdiction. Article 2 protects life; Article 3 protects against torture and inhuman or degrading treatment; Article 8 protects, among other things, family life and personal integrity; Article 13 concerns effective domestic remedies for arguable Convention claims. The Articles have different conditions. An overall systemic critique must therefore be followed by an individual or clearly delimited examination of duties. [49]; [57]; [55]; [54]; [53].

Under Article 2, the relevant duty to establish a framework, protect or investigate must be identified. The test of a specific threat to life may include what the authority knew or ought to have known about a real and immediate risk, and what reasonable protective steps were available. These criteria are not a universal prerequisite for all other rights. Article 8 can be violated by an inadequate decision-making process, even without an acute threat to life. [54]; [49]; [57]; [55]; [53].

6.2 Children and other dependants are entitled to effective protection

Z and Others v. the United Kingdom illustrates the state's positive duty to protect children against serious ill-treatment of which the authorities knew or ought to have known. Protection must be effective for the vulnerable individual. A division of public administrative functions or ongoing criminal proceedings does not remove the relevant authority's own protective duty. ([57]; in particular paragraph 73)

In the Danish material, failure to investigate indications of violence against children independently and waiting for delayed police investigations are specific criticisms. The allegation of violence remains an allegation until its factual basis is verified. The municipality’s receipt and failure to assess in time may be documented even where the underlying crime has not been finally proved. The legal duty to respond to a specific risk must not be confused with the evidential requirement for convicting someone of violence. [84]; [71].

6.3 Family life and distance created by authorities

In the case of the removal of a child, the legal basis, competence, consent or coercive basis, necessity, proportionality and decision-making shall be verified. On continuation, the current basis shall be retested. Previous bases and a later completed document are not self-explanatory proof of the legality of the entire period. [38]; [26]; [68].

Strand Lobben v. Norway emphasises that reunification work must begin at the start of placement, proceed promptly and be assessed with regard to the irreversible significance of time. Loss of family ties caused by authorities’ neglected reunification work must not become a basis for final severance. Restricted contact, cancellations, distance, support and the authority’s explanation of subsequently weakened relationships must therefore be linked in a single factual chain. [56].

6.4 Serious treatment and effective investigation

The assessment under Article 3 encompasses the nature, intensity, duration and effects of the treatment and the person’s age and health. The absence of an intention to humiliate does not in itself exclude a violation. Torture under CAT Article 1 has additional requirements concerning, among other things, severity, intention, purpose and official involvement; other treatment must be assessed on its own basis. The report does not automatically relabel every procedural error as torture. [55]; [49]; [57]; [54]; [53].

Where there is a substantiated allegation of serious ill-treatment, the investigation must be capable of establishing the incident and relevant responsibility. Lack of initial evidence of a named person's criminal culpability cannot automatically end the overall investigation of treatment, failures to protect and harm. The UN Committee against Torture's criticism of Denmark in 2023 makes this a specific issue for national follow-up. [66].

6.5 Effective remedy and the time taken by the entire course

Under the relevant rule, a remedy must be capable of preventing a violation, bringing it to an end or providing appropriate redress. A formally existing right of appeal is not a sufficient answer to a documented allegation that the specific access was delayed, blocked or without practical effect. Under Article 13, the arguable Convention claim and the remedies actually available are central. The application of Article 6 to civil rights or criminal proceedings must be clarified separately. [53]; [49]; [57]; [55]; [54].

§ 3 of the Act on Legal Protection and Administration in Social Matters requires prompt processing and published municipal deadlines; § 3 a clarifies, among other things, its application to remitted decisions in the specified areas. A notice of delay does not document that the processing time itself is lawful or reasonable. The municipality's specific deadline, actual reasons, the seriousness of the case and the entire subsequent course must be shown. ([97])

6.6 Disability and pre-intervention aid

The Disability Committee's concluding observations from 2024 criticise delayed or insufficient support for parents with disabilities. This provides a specific chain for examination:documented support need→assistance requested or known→the authority's delivery or omission→actual burden→assessment of parenting capacity→intervention. A situation the authority itself worsened through lack of support must not be used uncritically as evidence of an original personal deficiency. [62]; [2].

The child's safety and own rights must still be examined specifically. The strong argument is that necessary, timely support, accessible communication and independent fact-finding must form part of the basis before and during an intervention. A diagnosis or disability is not automatic evidence of unfitness. The individual legal consequence requires the specific law and records showing need, opportunity to act and omission.

The binding treaty rule must stand alongside the Committee's criticism: Article 23, paragraph 2, of the Convention on the Rights of Persons with Disabilities requires appropriate assistance to parents with disabilities; paragraph 3 requires early information, services and support for children with disabilities and their families; paragraph 4 prohibits separation solely on the grounds of the child's or the parents' disability. [386]. The consequence for the examination is specific: necessary support and its actual delivery must be investigated before the strain experienced without support is used as independent evidence against the parents. A statement of reasons that omits this step may rest on a deficiency created by the authorities rather than a documented condition for intervention in the individual case.

6.7 International State responsibility and personal responsibility

Acts of municipal and State bodies performing public functions may be attributed to the State internationally, including where powers are exceeded. The international-law test of attribution follows the ILC's articles 2, 4, 7 and 30-31 concerning breach, attribution, cessation and reparation. The articles are a codification project; the relevant binding obligation and customary-law rule must be identified. Lack of proof of one person's criminal culpability does not exclude a documented violation of rights by the State. [61].

Personal criminal responsibility follows its own requirements concerning the act and culpability. Sections 150 and 155-157 must be examined according to the act, duty, knowledge and law then in force. Gross or frequently repeated neglect under section 157 may be relevant even where intent to violate rights is not proved. The exceptions for publicly elected offices in sections 156-157 must be stated; they are not a general exemption from other criminal provisions. Later increases in penalties must not be applied retrospectively to a defendant's detriment. ([118])

6.8 Failure to protect is a legal analysis of duties

Conclusion: The documented failures of safeguards must be assessed as failures of rights protection where the disregarded safeguard was intended to secure a specific Convention right. Failure to protect denotes the report's analysis of this omission. Each point of responsibility is linked below to a rule, the known facts, a possible action and the result that failed to materialise. A citizen does not first have to prove an international crime in order to demand an end to an unlawful intervention, effective protection or an effective remedy.

The legal allegation has three evidentiary levels. First are the directly established Danish breaches of law and safeguards in the surveys' delimited cases. Next is the report's legal application of specific human rights and international law obligations to the facts. Finally are international violations already adjudicated, such as Aggerholm v. Denmark. The levels must be visible in each conclusion. A subsequent individual judgment may establish responsibility in further courses; the documented Danish errors and the systematic pattern already exist. [112]; [84]; [136].

6.9 The weight of the legal basis and the old knowledge of the authorities

The human rights conventions used are treaty obligations. A judgment of the ECtHR establishes an interpretation of the Convention and determines the particular case; ECHR Article 46 governs the respondent State's compliance with a final judgment. The Court's guides are official overviews of case-law, not new judgments. UN committees' general comments are interpretations by the treaty bodies, and their concluding observations on Denmark are sources of oversight and knowledge. The ILC's articles on State responsibility are a text of codification and progressive development; the relevant rule and its status must be identified in each application. The report does not use these different types of source as interchangeable decisions. [49]; [61]; [138].

For Denmark's documented knowledge, the years themselves have evidential value. Z and Others v. the United Kingdom was decided in 2001. The Human Rights Committee's General Comment No. 31 was adopted in 2004. Even before the period examined, it described duties to investigate, provide redress and counter impunity. Gäfgen was decided in 2010, Strand Lobben in 2019 and Aggerholm v. Denmark in 2020. The Danish oversight findings from 2006 onwards thus arose within an already existing protective framework. More recent clarifications are dated by their own source; they are not used to invent personal knowledge on the part of every historical employee. [57]; [138]; [55]; [56]; [136].

An authority's statement that reform has been implemented must therefore be checked against both the reform's own aims and the rights it was intended to protect. Organisational activity can be real without being sufficient. When new case samples continue to document missing assessments, hearings or follow-up, the evidentially sustainable conclusion is that the State had not secured those safeguards in the newly examined cases. An old promise of improvement does not cancel a subsequently established breach of duty.

6.10 Four protection tasks to be kept separate

Framework protection:law, competence, staffing, registration and oversight must be capable of securing the relevant right in practice. The report's repeated findings concerning children and the supervision survey concern this level in particular. A correct rule on paper does not document that the case procedures intended to implement it work. The specific criticism is the difference between a declared safeguard and new cases in which that very safeguard is missing.

Specific protection: An identified risk must lead to an assessment and the relevant available protective steps. Here, the first concern report, alarm, health information and recipient must be identified. Investigative protection: A sufficiently substantiated serious incident must be clarified on a basis capable of examining both the incident and responsibility. Redress: A favourable finding must be followed through to cessation, actual assistance and

appropriate redress. The conditions differ under Articles 2, 3, 8 and 13; the specific tests follow from the named judgments and provisions below. [387]; [388]; [389]; [53].

The four-part analysis closes an important accountability gap. An authority cannot answer a lack of urgent protection solely by pointing to general supervision, answer a deficient investigation by pointing to the absence of an individual conviction, or answer undelivered assistance by pointing to a favourable decision. The report demands an answer concerning the specific neglected task and its particular timeline.

6.11 Protection of life and a risk the authority knew or should have known

Legal rule: Osman v the United Kingdom, 28 October 1998, paragraph 116, links the specific duty of protection under Article 2 of the ECHR to a real and immediate risk to life of which the authority knew or ought to have known, and to reasonable steps available to it. Kurt v Austria, Grand Chamber, 15 June 2021, paragraph 160, links the assessment to an independent and specific risk assessment. The Court's Article 2 guide identifies these tests in paragraphs 23-25. [387].

Application: The disciplinary summary's account of a helpless citizen with Parkinson's disease, who was not found until more than 42 hours after the call, provides a specific line of inquiry into protection of life and integrity. The original emergency call must show the condition and location reported, the person's ability to help themselves and the risks the recipient could assess at the time. The duty log and deployment decisions must show the response available. The summary supports criticism of the omission described; it cannot replace the emergency call as evidence of every element of Article 2. The demand is for an independent investigation of the failure to provide protection and the subsequent health consequences, not an assumption that deployment decisions were correct.

Where psychiatric assistance is delayed, known suicide risk or another specific danger to life must likewise be traced to the responsible clinical or administrative recipient. A general breach of a diagnostic assessment deadline does not alone document this knowledge in each course. It documents a rights and capacity problem that must be assessed independently; specific warning signs may additionally trigger the operational obligation to protect life. This precise delimitation makes it possible to pursue both lines of responsibility without losing the already documented breach of the time limit.

6.12 Protection against serious ill-treatment and a precise causality requirement

Legal rule: Z and Others v the United Kingdom, Grand Chamber, 10 May 2001, paragraphs 73-75, concerns effective protection of children against known serious ill-treatment. O'Keeffe v Ireland, Grand Chamber, 28 January 2014, paragraph 149, does not require proof that the harm would certainly have been avoided; reasonable measures that were omitted and had a real prospect of changing or limiting the outcome may be sufficient. The O'Keeffe reasoning is located in the Article 3 guide, paragraph 121. [57]; [388].

Significance of the evidence: The municipality's own receipt of a specific concern report about violence can document a duty to assess the child even before a criminal judgment determines who committed the violence. Municipal cases in which the police investigation was awaited without an independent relevant assessment must be examined for the lost opportunity for timely protection. No certain hypothetical rescue should be invented. The decisive task is to prove which reasonable steps were actually available and how the omission removed a real opportunity for protection. [84].

Responsibility and demands: The child's own statements, the original safeguarding notification, its receipt, the professional assessment and the action actually taken must be secured. The protection and investigation track must include municipal management and follow-up where their knowledge is documented. Any subsequent decision not to proceed with criminal prosecution must be read according to its precise reasoning; it does not automatically determine whether the municipality fulfilled its own duty in light of the information it held. This examination applies to serious treatment within the scope of Article 3, while other shortcomings in care and procedure are examined under their own rules.

6.13 Procedural safeguards for family life form part of substantive protection

Legal rule: Strand Lobben and Others v Norway, Grand Chamber, 10 September 2019, paragraphs 202-213 and in particular 208, concerns procedure, proportionality and efforts towards reunification. The guiding principle is that a placement should, as a starting point, be temporary and followed by timely measures towards possible reunification; the current basis and the family's participation must be examined. The Article 8 guide, paragraphs 422-431, identifies the requirements and the Court's stricter scrutiny of further restrictions on contact. [56]; [389].

Application:the documented deficiencies concerning hearing the parties, placement decisions and contact decisions in Copenhagen concern precisely the family’s ability to influence and challenge the intervention. A year without a formal decision on a requested contact arrangement may deprive the family of timely access to review of necessity and scope. A later decision does not document the intervening period’s basis. Each course must connect actual contact, cancellations, reasons, support and later assessment of the strength of the bond. [84].

Legal departure and consequence: if the authority’s own restrictions on contact weaken the relationship and that weakening is later used to justify further severance, the original decision and its effects must be included in the legal review. The report’s forceful demands are prompt fresh review, a specific contact plan, support and correction of a documented unlawful basis. Conducting a new process is insufficient if the distance already created is uncritically used against the family.

6.14 The Convention on the Rights of the Child requires protection, supervision and continuing review

Legal rule: Article 3, paragraphs 1-3, of the Convention on the Rights of the Child concerns the child's best interests, necessary protection and institutional standards, including suitable staff and competent supervision. Article 9 governs separation, participation and contact; Article 12 concerns the child's opportunity to be heard. Article 18, paragraph 2, requires appropriate parental support; Article 19 concerns protection against violence and neglect, as well as effective procedures and follow-up. Article 24 concerns health, Article 25 periodic review of placement and treatment, and Article 39 rehabilitation following the forms of abuse covered. [390].

Evidence and significance: The repeated absence of the child's involvement, a current assessment basis and an action plan cannot be reduced to errors in forms when it removes the knowledge and oversight on which protection of the child relies. Rigsrevisionen's new placement trajectories show that the State still did not secure all the Danish statutory safeguards examined. The report's legal criticism is that the missing safeguards affect the functions required by the Convention on the Rights of the Child: informed protection, the child's participation and effective follow-up. The precise application of the Convention is carried out for each affected case and each documented safeguard deficiency. [112].

Responsibility and demands: the supervisory dimension of Article 3 makes the quality of the institution and staff a rights issue. Municipal reconsideration must therefore establish both the child’s current circumstances and the supervision of the facility and the relevant responsibilities. The Article 25 dimension requires current information on continuing need and treatment; the original decision is not a permanent certificate of protection. The demand is for documented periodic review with the child’s participation and actual correction of the conditions found.

6.15 The Disability Convention links assistance, participation and independent scrutiny

Legal rule: Article 4 of the Convention on the Rights of Persons with Disabilities requires implementation and changes to discriminatory practices; Article 5 concerns equality and reasonable accommodation; Article 7 concerns children's rights and adapted assistance in expressing their views. Article 13 concerns effective access to justice; Article 16 concerns protection against exploitation, violence and abuse, including independent monitoring under paragraph 3. Article 19 concerns independent living and necessary support services; Article 23 family life and parental support; Article 25 access to healthcare without discrimination on the grounds of disability. [386].

Application: an award without actual assistance, repeated remittal for reconsideration without delivery, and proceedings that are inaccessible to the person affected must be examined as distinct failures. The absence of assistance can both harm the person and skew the assessment of the family's functioning. The concrete evidence consists of the award, need, delivery, communication and the authority's use of the situation without support in a later assessment. The right to support must not disappear from the record merely because an administrative finding has been made in the citizen's favour.

Demand: An actually accessible complaint and investigation process must be provided, and assistance documented as necessary must be followed through to delivery. Where there is specific information about violence or abuse in a residential facility, oversight must demonstrate its independence, investigative steps and protection of the vulnerable individual. The report does not require an individual to prove aggregate harm at national level in order to have their own documented entitlement fulfilled. State responsibility for failures of implementation and the specific claim for assistance must be capable of being pursued simultaneously.

6.16 A remedy granted must also be implemented

Legal rule: Article 2, paragraph 3, of the ICCPR requires an effective remedy also against persons acting in an official capacity, and enforcement of remedies that have been granted. Article 7 concerns severe treatment; Article 9 liberty; Article 17 family life and privacy; Article 24 the child's special protection; Article 26 equality. The provision's separate enforcement component is decisive when a favourable decision is not translated into action. [391].

Legal interpretation:General Comment No. 31,paragraphs 15-17 and 20,connects accessible effective remedies with investigation, cessation, reparation and necessary steps to prevent recurrence; the remedies must also work in practice. Paragraph 4 covers all branches and levels of public power. Paragraph 8 concerns relevant protection against private abuses. Paragraph 14 describes the implementation obligation as immediate. [138].

Application and responsibility: the report's distinction between remittal for reconsideration and assistance, between an award of compensation and payment, and between closure of supervisory proceedings and corrected practice here acquires an explicit basis in international law. For the particular protected right, the state must be able to document which relevant remedy was actually implemented. Non-delivery following a documented finding in the party's favour must not disappear when a body records the case as closed. The requirement covers the date of receipt, the date of implementation, outstanding losses and the body that was to ensure implementation.

6.17 Investigation and accountability counteract recurrence

Legal interpretation:General Comment No. 31,paragraph 18,warns that impunity contributes to recurrence. For the serious violations covered that also constitute crimes, those responsible must be brought to justice; public status must not give exemption from responsibility. Failure to investigate and prosecute may constitute independent violations. This is the treaty committee’s interpretation of the ICCPR, not a judgment on every Danish administrative error. [138].

Legal rule: Gäfgen v Germany, Grand Chamber, 1 June 2010, paragraph 125, emphasises suspension during investigation and trial where state employees face criminal charges of ill-treatment, and dismissal upon conviction. The Court's Article 3 guide, paragraphs 154-156, links this to combating impunity and inadequate delays in accountability. [55]; [388].

Application:the material’s disciplinary delays and exemption from record-keeping show specific mechanisms that may prevent a tangible response. Where the underlying incident concerns a serious violation of integrity, the response process must also be examined under these international requirements. For other administrative errors, the demand is pursued under Danish law on duties, discipline and compensation and the relevant protective rule. The international point on suspension is not applied as an automatic demand for dismissal for every procedural deficiency. [100]; [67].

Consequences, responsibility and demands:a case must show who committed the action, who received the warning, who could protect subsequent citizens, and why an accountability response was weakened or lapsed. In cases of documented serious recurrence, continued access to interventions must be justified and reviewed. The oversight authority's own delay must be investigated separately. This is a current protective task, not merely a subsequent assessment of culpability.

6.18 An order does not excuse torture and the State retains its responsibility

Legal rule: Article 2, paragraph 3, of the Convention against Torture rules out a superior's order as a justification for torture. Article 11 requires systematic review of rules and practices concerning deprivation of liberty; Articles 12-13 require prompt, impartial investigation and a protected complaints process; Article 14 requires redress and the opportunity for rehabilitation for victims of torture. Article 16 requires prevention of other cruel, inhuman or degrading treatment covered by the Convention and applies, among others, Articles 10-13 in this area. [392].

Application: The Danish 2017 obedience guidance cannot be read as an international free pass for serious forms of treatment. It itself distinguishes doubtful orders from clearly unlawful or criminal orders. The documented respondent information about management control and the specific responses to lawful criticism must be traced upwards to the decision and warning. Where an order maintains an intervention contrary to rights, the state's protective responsibility remains, even though the implementer's individual responsibility requires a separate examination of culpability. [133]; [47].

Demand: In cases of deprivation of liberty and coercion, the authorities must preserve the order, instructions, warnings, necessity assessments and ongoing medical monitoring. A general training initiative cannot answer for a specific continuation that lacked a basis. Public oversight must investigate both the intervention itself and the management or investigation structure that allowed it to continue. The Danish complaint findings on duration provide specific cases in which to begin this review. [51].

6.19 International responsibility cannot be eliminated by dividing it up

Legal rule: ILC Articles 2 and 4 on state responsibility connect treaty violations with attribution of the conduct of public organs, including local and judicial organs. Article 7 covers conduct in an official capacity despite exceeding authority. Article 14 distinguishes continuing violations from merely continuing harmful effects; Article 15 requires the relevant primary rule to define an aggregate series as wrongful. Articles 29-32 concern continued performance, cessation, relevant assurances against recurrence, reparation and the inability to invoke domestic law as an excuse. Articles 34-38 specify forms of reparation and interest; Articles 40-41 concern serious breaches of peremptory norms. [61].

Significance of the evidence: Denmark bears international responsibility even where the citizen deals with a municipality, region, supervisory authority or court. Each body's actual powers must still be shown to allocate the task and personal responsibility. But the citizen's right must not be left unprotected by bodies merely pointing to one another. When a body rejects a particular avenue on jurisdictional grounds, the report requires a record of who actually assumed the relevant protection and remedial task.

Private harm and public responsibility must be examined in separate chains. Private abuse does not automatically become the State's own act. The State's documented failure to protect, investigate or exercise relevant oversight may, however, be its own violation. For private services, any exercise of public authority and specific State instruction must be identified separately. This distinction makes the accountability criticism precise: the municipality must answer for its own known omission without waiting for all private acts to be attributed to it.

6.20 Scope, recurrence and continuation have different legal effects

Conclusion: The material's large case samples, many years and several areas of public administration strengthen the evidence of a governance and oversight problem. This is an independent analytical conclusion. It does not turn every historical action into one uninterrupted treaty violation. A continuing restriction on contact without legal authority, an ongoing coercive intervention and a fulfilled historical decision with residual harmful effects must be dated differently. This temporal assessment is necessary both for demands for cessation and for responsibility.

In child welfare, the surveys from 2006 onwards document new case samples with repeated deficiencies in safeguards. This supports the allegation of continuing insufficient protection of rights on the points examined. In Langeland, the supervisory authority's receipt, rejection, closure and the Ministry's later demands must be linked to the affected cases. Knowledge of systemic errors is evidence of a need for oversight; precise knowledge of an individual child's risk is found in that case's own records. The two lines of evidence complement each other. [112]; [76]; [106].

Where a series involves the same actor, every documented intervention must be recorded alongside the first warning and continued service. Recurrence after documented knowledge may reveal a further omission by management or oversight bodies. Responsibility for the first act must be distinguished from responsibility for allowing the risk to continue. The demand is a chronological accountability map recording the act, recipient, powers, chosen response and next incident.

6.21 Cessation and redress must be visible in the citizen's situation

Legal starting point: Articles 26-27 of the Vienna Convention express treaty performance in good faith and the principle that domestic law does not justify a treaty violation. The relevant temporal treaty basis must still be identified. For established human rights violations, redress follows from the Convention applied and its remedies, supplemented by the relevant general rules of state responsibility. [139]; [49]; [391].

Use: A course, new registration, additional post or completed supervision cannot in itself document termination. The report requires for each known problem three verifiable steps: what happened to the previously affected; what happens in new cases; and what the control does if the same error is found. Measurements shall maintain the same or explained criteria, avoid double counting and indicate actual contact, support provided, cessation of action or payment. An improved administrative objective must not conceal a worsening actual waiting time.

Specific demands:reopening and a corrected basis must be followed by actual implementation. Documented harm must be assessed with duration and causal contributions; relevant treatment and rehabilitation needs must be evaluated. An apology may provide relevant acknowledgment, but cannot replace missing assistance or a necessary protective response. A declaration of permanent improvement requires repeated review in new cases and an effective response to recurrence. The report can demand this oversight; it cannot certify perpetual future freedom from errors.

6.22 Responsibility to protect and independent human-rights protection

Legal and political basis: The UN World Summit Outcome, A/RES/60/1 of 2005,paragraphs 138-139,concerns protection against genocide, war crimes, ethnic cleansing and crimes against humanity. Paragraph 138 places responsibility with the state; paragraph 139 concerns international assistance and possible collective action through the UN under the Charter's conditions. [140].

The Secretary-General's A / 63 / 677 of 2009, paragraphs 10-11, describes three pillars: State protection, international assistance and capacity building, and timely appropriate international response. Paragraphs 3 and 10 maintain both the limited scope of application and the other existing international law protection obligations. [141].

Application: the report's evidence must therefore be examined directly under the ECHR, ICCPR, Convention on the Rights of the Child, Convention on the Rights of Persons with Disabilities, Convention against Torture and relevant national rules. Failure to fall within R2P's specific scope cannot be used to reject these broader duties. A family may be entitled to protection and reparation even where no international crime has occurred. The clear allegation of Danish responsibility is known, repeated failure adequately to discharge these specific protective duties.

Significance under international law: the R2P perspective makes the question of the State's own protection visible, but the conclusion concerning massive documented failures rests here on the separate rights and chains of evidence. If a particular sequence is documented as falling within one of the four covered categories, that separate perspective must also be examined. The volume of case-processing errors alone does not prove that category. The report therefore demands effective human-rights protection now and preservation of the material required for any more stringent legal characterisation.

6.23 International individual criminal law requires a separate evidential chain

Legal rule: Article 7 of the Rome Statute requires a widespread or systematic attack against a civilian population with knowledge of the attack; Article 7, paragraph 2, point a, links the attack to repeated acts of the kinds listed and to a state or organisational policy. Article 7, paragraph 1, points e, f, h and k, covers, subject to their further conditions, severe deprivation of liberty, torture, persecution and other comparable inhumane acts. Article 30 governs intent and knowledge. [142].

Evidentiary test for the context: the report's repeated Danish breaches of safeguards prove a serious systemic problem. An Article 7 allegation must additionally identify the specific acts covered, the civilian population attacked, the connection between the events and a documented policy concerning that very attack. Budget management, breaches of law, weak oversight and exemption from responsibility are relevant leads; none of them alone satisfies this overall contextual element. The evidence must be found in instructions, contemporaneous decisions, connections between actors, actual implementation and knowledge of the relevant acts.

Evidential test for the act: In cases of serious deprivation of liberty, actual control, absence of a lawful basis and duration must be documented. For alleged torture or another inhumane act, the treatment, intensity, control, consequences and required culpability must be documented. For persecution, the specific group connection and intentional severe deprivation of rights must be established in their own chain. An Article 3 judgment is strong evidence of the Convention violation adjudicated; it is not in itself a determination of the context and culpability under Article 7.

6.24 Immunity, managerial responsibility and effective domestic accountability

Legal rule: Article 27 of the Rome Statute excludes official capacity as a ground for exemption from responsibility before the ICC. Article 28, subparagraph b, on civilian superiors requires effective authority and control, together with the specified knowledge or conscious disregard of clear information and failure to take necessary reasonable steps. Article 17 concerns genuine national prosecution and, among other things, shielding, incompatible delay and lack of independence. [142].

Application: The central line of inquiry into individuals is who could actually stop the intervention and received the warning, not who merely held a title. A minister's, municipal manager's or professional head's responsibility must be traced through decision-making powers, contemporaneous information and act or omission. The international criminal-law test can be applied only once the basis for the crime is identified. The necessary review of Danish mechanisms shielding responsibility and lost sanctions is already required under the national and human-rights tracks.

Demand: Any international criminal-law documentation must contain both incriminating originals and originals that specifically qualify the account, explainable selections, and precise links between actors and dates. It is necessary to obtain

decisions on why relevant national investigations were closed and what was actually investigated. The existence of a complaints body is not proof of investigation of the person's actions. The report concludes that there are documented systematic failures of protection and oversight; the final Article 7 classification remains a separate evidential requirement, with each missing element named.

6.25 Delayed review and a remedy capable of protecting in time

Legal rule: Kudła v Poland, Grand Chamber, 26 October 2000, paragraphs 147-159, establishes the separate requirement under Article 13 for an effective remedy against an unreasonable duration of proceedings. Sürmeli v Germany, Grand Chamber, 8 June 2006, paragraph 99, concerns preventing or remedying delay. The reasonable-time requirement under Article 6 applies to the civil rights and criminal proceedings within its scope; the relevant scope of application must be identified. The Article 13 guide, paragraphs 146-156, identifies these requirements. [53]; [49].

Application: The report examines the entire process from application or intervention to actual redress, because a narrowly measured authority processing time may omit the period during which the individual remains without assistance or a reviewable decision. An increased time target cannot determine whether a particular remedy worked in time. In family matters, the child's time-dependent relationship and the specific continuing intervention must be included. With coercion, it must be possible to secure cessation of the intervention without awaiting a later financial assessment.

Consequence and demand: The competent oversight body must show what access the individual actually had to have the act stopped, the missed deadline addressed and relevant loss remedied. A compensation action that overturns an earlier refusal shows both the original error and an actual judicial correction. The number of calendar days alone does not determine the Article 6 issue; the case's specific procedure, periods of inactivity and significance must be established. At the same time, a correct final decision does not document that all relevant redress has been implemented.

6.26 Deprivation of liberty and protection of persons under public control

Legal rule: Article 5, paragraph 1, of the ECHR requires one of the listed grounds and lawfulness for deprivation of liberty. Paragraph 4 requires speedy judicial review of lawfulness and release in the event of unlawful deprivation of liberty; paragraph 5 concerns compensation for a violation of Article 5. Article 9 of the ICCPR has its own basis for liberty and review. [49]; [391].

Application: The report's interventions restricting liberty must first be classified according to their actual intensity, duration and level of control. Belt restraint, psychiatric hospitalisation, arrest and a social support decision are different acts. Article 5 must be linked to actual deprivation of liberty, while, for example, the nature of treatment and family contact also raise distinct issues under Articles 3 and 8. The demand is for the original decision, the legal basis in force at the time, every decision to continue, actual cessation and available judicial review.

Consequences and responsibility:an organisational transfer or new internal registration does not remove an ongoing intervention without legal authority. Oversight must show that the competent body could actually examine the current basis and end the documented unlawful deprivation of liberty. The person's vulnerability and opportunity for assistance must be reflected in practical access to review. This is a separate protective requirement directed at the citizen, even though personal criminal responsibility has not yet been determined.

7 Children and families: protective safeguards that fail across new generations of cases

7.1 The historical repetition is the question of responsibility itself

Conclusion: The authorities' knowledge of serious errors in children's cases is documented through repeated investigations since 2006. Their subsequent recurrence cannot be defended as a new or unknown problem. The claim of systematic failure rests on newly selected samples of cases and persistent failures in the same protective functions, not on copying the result of a single investigation across twenty years.

The authority's specific statement and original evidence: The studies from 2006 and 2008 classified respectively 23 of 101 and 92 of 143 placement decisions examined as non-compliant with rules or practice. In 2008 deficiencies in the basis and formal safeguards were included. In 2011 errors were found in 67 of 81 relocation and return-home cases examined. The originals' selection and criteria are set out in the studies' methodology sections with locators in the source register; the stated fractions are not national proportions of all Danish children. [16]; [17]; [18]; [29]; [26]; [112].

Discrepancy and significance of the evidence: the 2019 pilot included 228 cases that had not been appealed, from 12 municipalities. 70 of 228 lacked an up-to-date child welfare assessment, 64 of 100 exceeded the deadline examined, and 99 of 226 lacked the child interview covered by the study. The errors were therefore also present without a complaint from a citizen. They cannot be dismissed as a distinctive feature of already contentious appeal cases. At the same time, this means that appeal statistics alone must not be used as a measure of all unlawful practice. [24].

Relevant rule and omission: The rules then in force on assessment, consent, participation, plans and follow-up must be applied according to the time of the case. Their function is to ensure that interventions and assistance rest on a specific, current basis. The authority's omission of a necessary step weakens precisely the basis later used to legitimise the intervention. When failure recurs after public oversight, management's implementation and control must also be examined.

Legal departure, consequence and responsibility: A documented procedural deficiency must be traced to its significance for the child’s right to be heard, assistance, placement, contact and review. Where jurisdiction, valid consent or the basis for intervention is missing, the criticism concerns the legality of the intervention itself. Where only a particular formal requirement has been checked, that precise requirement must be pursued with full force. Responsibility includes the municipality, the competent decision-maker and the oversight bodies that received specific knowledge and then failed to provide required follow-up.

Specific demand:for every historical review finding, produce the responsible recipient’s date, the correction decided, reconsideration of affected cases, actual assistance or cessation, checks for recurrence and assessment of responsibility. There must be an unbroken connection from the finding to the citizen’s legal position. Absence of that connection does not document that the problem is closed.

7.2 Child Case Barometer: recurrence and precise denominators

The barometer surveys for 2020-2024 show the following error counts and relevant denominators. The year names the survey; it is not a uniform cohort of decisions made in that particular year. Rows overlap, and different requirements have different populations. [19]; [20]; [21]; [22]; [23].

Current child welfare assessment missing or not updated: 2020 215/731; 2021 187/692; 2022 252/687; 2023 209/744; 2024 143/709. Original figures: [19]; [20]; [21]; [22]; [23].

Examined time limit not met: 2020 219/330; 2021 146/367; 2022 185/284; 2023 208/314; 2024 187/371. Source figures: [19]; [20]; [21]; [22]; [23].

The statutory requirement for a child interview before the decision was breached: 2020 322/717; 2021 273/699; 2022 309/691; 2023 294/746; 2024 248/708. Source figures: [19]; [20]; [21]; [22]; [23].

Action plan missing: 2020 152 / 735; 2021 87 / 708; 2022 161 / 697; 2023 127 / 765; 2024 120 / 724. Original figures: [19]; [20]; [21]; [22]; [23].

Three-month follow-up is missing: 2020 58 / 118; 2021 49 / 87; 2022 46 / 102; 2023 144 / 475; 2024 118 / 473. Original figures: [19]; [20]; [21]; [22]; [23].

The population for three-month follow-up changes from 2023: later barometers examine follow-up across relevant types of measure, while older figures concern placement subsamples. A jump in the count or percentage in this row therefore cannot alone be used as proof of changed practice. Comparison requires the same case type, the same requirement and the same measurement period. See the methodology in the Child Case Barometer 2022,pp. 53-54, 2023,pp. 41-43,and 2024,pp. 42-44.

Reconsideration is missing or unclear in the study's category: 2020 95/203; 2021 121/268; 2022 103/219; 2023 116/204; 2024 83/168. In 2024 the last figure divides into 79 without and 4 unclear. The combined category must therefore not be called 83 securely documented omissions. Original figures: [19]; [20]; [21]; [22]; [23].

The conclusion is persistent, extensive failure of safeguards, while certain measures improve in the later samples. The fall from 209/744 to 143/709 for the absence of a current assessment is a better recorded result in this comparison. It does not prove full lawfulness or the cessation of other errors. The pointed criticism is that significant errors still occur after many years of known problems, and that the authorities do not present a complete chain from each individual error to a rectified life situation.

In 2024, 74 cases were included among those classified as satisfying the interview requirement because the Appeals Board inferred an exception that did not appear in the original case. This is a separate evidentiary problem: the subsequent reviewer’s explanation must not be presented as the municipality’s contemporaneous reasoning. The requirement is to identify the actual information in the case, the lawful exception and the significance of the missing contemporaneous documentation. [23].

7.3 Placements 2022-2024 and new state knowledge in 2026

The National Audit Office’s new investigation established at least one of the measured breaches of law in 69 per cent of 3.148 selected first placement courses from 83 municipalities. This is a new and serious line of evidence after the older surveys. It concerns decisions from 2022-2024 and is follow-up published in 2026; it must not be inserted as a new full-year series for 2026. [112].

The selected case histories document continuing failure despite known requirements. They do not cover every substantive and discretionary question concerning the intervention. Approval under the criteria examined therefore does not fully validate the entire case, and a breach under one criterion does not automatically prove that placement itself lacked substantive justification.

The chain of responsibility must be linked to who made the decision, who controlled it and who, through previous investigations, had learned of the relevant type of error. The responsibility of the municipality for the specific decision and the responsibility of the State for an inadequate control system can exist at the same time. A general measure in 2026 does not eliminate the loss already suffered by a child in 2022.

The demand is documented reconsideration of the identified errors, a reasoned assessment of continued intervention, delivery of missing support and oversight showing actual change in new cases. National follow-up must specify the type of error measured, the comparable sample and the improvement actually achieved. Municipalities’ statements that they are paying attention are not such a result.

7.4 Copenhagen: when the authority itself circumvents the guarantees

Conclusion: The Copenhagen investigation documents specific circumstances in which labels, pressure and the incorrect exercise of powers weakened families' rights. The overall category of 77/77 with at least one deficiency proves a pervasive failure in the material examined. The most intrusive circumstances must be pursued individually.

Original evidence: The examination of 77 children's cases from three local units found, among other things, 42/76 apparent failures to carry out relevant consultations of the parties, 50/70 failures to provide guidance on voluntariness and compulsion, 67/76 failures to provide guidance on appeal rights and 68/76 failures to issue a decision on the place of placement. The precise denominators are not interchangeable. The category 23/77 concerning competence, legal authority and misuse of powers includes both established circumstances and concrete indications; it does not represent 23 definitively established placements without legal authority.

Discrepancy: six of 16 relevant contact arrangements were actually supervised, although described as supported. An authority cannot create powers by renaming an arrangement. The actual supervision and its restriction of contact must be assessed against the decision the competent body was required to make.

Rule, omission and consequences: the rules governing competence, the legal authority for contact arrangements and the Public Administration Act's requirements concerning hearing the parties, giving reasons and providing guidance protect the family's ability to understand and challenge the intervention. A de facto supervised arrangement without the requisite decision deprives the family of this protection. The Article 8 assessment must encompass the actual restriction on contact and its entire duration. [71]; [84].

The twins' case is particularly serious. The municipality communicated the placement decision to the mother in hospital before documented consent and changed the form's four months to one to obtain a signature. The mother wanted assistance at home and described the pressure. The evidence is the report's account of the records; the hospital records, both versions of the form and contemporaneous statements must be produced before all individual factual elements are established. An authority seeking to rely on voluntariness must show valid, informed consent from the necessary rights holders. [84]; [71].

In another case, the municipality organised collection and paid for accommodation and transport with a former foster family, while the arrangement was called private. The father sharing parental responsibility was contacted three-four months after the apparently voluntary placement decision. Payment, actual organisation and decisions must show who acted as an authority and the basis for each period. An administrative label cannot replace consent or a compulsory decision by a competent body. [84]; [71].

In the case of the three sisters, the municipality assisted the father against the mother and recommended withholding the children while the mother still shared parental responsibility and held residence rights. This provides a specific basis for examining improper assistance to one party, powers and possible complicity. Legal scrutiny must follow the original parental-responsibility decisions and dates; it must not stop with the municipality's later account of cooperation. [84]; [71].

Responsibility and demand: For each sequence of events, the original decision, basis of rights, consent, actual contact and cessation, responsible function, management's knowledge and later redress are required. The documented abuse of authority must be addressed now; application of criminal law to an individual must be built on the additional evidence of the act and culpability. An undocumented allegation of personal criminal responsibility must not be used as a reason to abandon the already sustainable demand for cessation and reparation.

7.5 The hidden time before a decision and after a favourable finding

In the Copenhagen course, parents repeatedly requested more contact, while the formal decision appears only more than a year later. The documented consequence is a prolonged lack of a reviewable decision. The source does not prove zero contact throughout the period. This precise criticism is serious enough:the authority may block the ordinary appeal route by failing to make the decision the citizen needs to appeal. [84]; [71].

The account of time must begin with the first documented need or intervention. It must continue through reconsideration, complaint, remittal, a new decision and actual change in the child's life. An appeal body's own processing time is only one interval. The total loss of family life may be longer, and restricted contact must be measured separately in visits, hours, cancellations, travel distance and supervision. [33]; [84]; [36]; [91].

The return-home transition period of up to six months under the Children's Act is not a general requirement for a further six months of separation. The seven-day deadline laid down in § 102, subsection 1, of the Children's Act when termination of a voluntary placement is requested concerns the decision on returning home, not automatically the physical return home. Each period must be examined against the specific decision and the rule in force at the time. A later return-home transition period does not legalise an earlier removal without a basis. [38]; [26]; [68].

The demands are cessation of the specific unlawful arrangement, prompt review of the continuing basis, an actual plan for lawful contact and a separate account of losses already suffered. A reunification objective without dates, delivered support and actual contact is another declaration of activity.

7.6 Lack of protection against violence must be tested independently

The Copenhagen report describes notifications of violence that were not investigated further and cases in which the municipality awaited a delayed police investigation. The notification proves receipt of knowledge; it does not on its own prove every reported act of violence. The documented omission must be examined as a failure to investigate independently and promptly. [84]; [71].

The municipality's protection assessment has its own purpose and duties. A criminal investigation cannot mechanically replace the assessment of the child's current safety. Whether Article 2 or 3 has been violated depends on the relevant risk, knowledge, opportunity to act and omission. Z v. the United Kingdom shows precisely that prolonged, known, serious ill-treatment and failure to protect can give rise to State responsibility. [57]; [49].

The strong demand is to connect the safeguarding notification's wording and receipt to each authority's action, internal risk assessment, the child's actual residence and subsequent harm. Protection against violence and protection against removal without legal authority must both be examined specifically. Neither duty permits the other to be set aside.

7.7 Langeland:the supervisory authority knew of the failure and had to be reviewed again

Conclusion: Langeland documents a specific oversight process in which continuing legality problems and inadequate scrutiny of remediation became known over several years while supervisory cases were rejected or closed. The ministry's new demands in May 2026 direct criticism towards the reasons given by the oversight body itself.

Original evidence: In the 12 cases from 2023 selected by the municipality, there was doubt about adequate assistance in seven; follow-up was delayed in all nine relevant cases, participation in setting goals was absent in all nine relevant cases, and parental support was absent in all three relevant cases. One investigation took 13 months, and a placement plan was drawn up 11 months later. The selection was made by the municipality and is not a random national sample. It shows specific, new deficiencies following previously known criticism.

Chain of knowledge: in November 2022, the supervisory body had considered a review of relevant closed cases. In May 2024, the task force found continuing low compliance with the law and a lack of quality control of remediation; Ankestyrelsen received the material in June. The municipal council acknowledged problems in

February 2025. Ankestyrelsen declined to open a new supervisory investigation in August 2025. Following a new task-force programme in May 2026, the agency closed its supervision; later that month, the ministry required a fresh assessment of legality, sanctions and remediation. [123]; [76].

Discrepancy:information about additional staff, consultant hours and new management supervision showed initiatives. These did not in themselves show that the relevant breaches of law had ceased or that the old cases had been corrected. Closing supervision without that connection risks making the authority's plan the citizen's only protection.

Relevant rule, departure and responsibility: the municipality has a duty to process cases lawfully; the supervisory authority must exercise its powers on a legally and factually sufficient basis. The National Audit Office's national findings on supervisory responses must be read alongside the specific Langeland course of events, but must not replace its case records. The Appeals Board must explain how the information about continuing errors was examined and why its basis for closing the matter was sufficient. [106]; [89]; [76].

Demand: Produce the full basis for the decision, not merely the closing letter; identify all affected cases; document correction and the assistance actually received by the individual; give reasons for the assessment of enforcement powers; and document new practice through comparable scrutiny. It is insufficient for a new programme to run until 2028 if an individual remains subject to a specific unlawful omission now.

7.8 Parents with disabilities and Authority-created strain

The Disability Committee's criticism in 2024 provides a direct reason to examine whether missing parental support is later used to justify intervention in the family. The evidence must trace need, application or the authority's knowledge, actual support, burden, assessment of parenting and decision. [62]; [2].

If an authority fails to provide relevant support and then treats the resulting exhaustion or practical shortcoming as evidence of a personal parental failing, the causal and legal discrepancy must be challenged. Merely attaching a disability label to the individual is insufficient. The authority must show what the person could do with the support to which they were entitled, and how the child's own needs were assessed.

Required legal consequence: independent fresh fact-finding, relevant support, review of the premises created by the authority's omission and a new decision excluding unverified information or erroneous attribution of causes. Any compensation claim must quantify consequences separately and link them to the documented omission.

7.9 Legal evidential chain concerning known massive failures of safeguards

Conclusion: In the children's field, there is documentation of persistent failure to implement central safeguards following repeated national warnings. Rigsrevisionen's 2026 review found at least one of the breaches of law examined in 69 per cent of 3.148 selected first placement processes from 2022-2024. This is a massive finding in this sample. The older practice studies and barometers of unappealed cases document new processes with the same types of shortcomings in safeguards. There is thus both a long-standing chain of knowledge and later factual findings.

The authority's statement and original evidence: a general statement of improved quality can be tested only against its specific objectives, underlying data and date. It is confronted here with the surveys' categories concerning a current factual basis, interviews, involvement and plans. The historical and more recent samples must not be added together to construct a national total of persons. Their significance is documented recurrence after warning and failure to secure the measured rights in the new cases.

Relevant rule, action and legal departure: the participation and decision-making process under ECHR Article 8, Articles 3, 9, 12, 19 and 25 of the Convention on the Rights of the Child, and the Danish provisions then in force must be connected to each type of error. Failure to investigate weakens the individual basis for intervention; failure to hear the parties may exclude decisive information; failure to follow up may leave a continuing need or an ongoing intervention without legal authority unexamined. These are specific functions of rights that the state had organised safeguards to protect. [56]; [390].

Significance for the outcome, responsibility and demands: The material supports a systemic accusation of insufficient protection of these safeguards. In each case, it must be shown what the deficiency meant for intervention, contact, support and review; a substantively incorrect placement requires proof of that specific result. The demand is reconsideration of identified errors, prompt checks on the continuing basis for intervention and public verification of new cases. Ministry, supervisory authority and municipality must each document receipt, decision and actual correction. The international assessment of responsibility cannot conclude by examining only the individual frontline employee.

7.10 Legal evidence chain on contact and absence of protection

Conclusion: The Copenhagen findings document deficiencies in interventions and review affecting the family’s specific legal position. Original evidence: the Citizens’ Adviser found deficiencies in all 77 cases examined, including failure to hear the parties in 42 of 76, absence of the required placement decision in 68 of 76 and absence of a contact decision in 25 of 76. Example 6 concerns more than a year before a formal decision on requested contact. The different denominators and errors must be preserved; the figures do not represent separate groups of children.

Discrepancy and rule: an actual arrangement involving intervention cannot be justified merely by referring to the family's having received a decision later. ECHR Article 8 and the Strand Lobben test require examination of the basis for decision-making, participation and the development of the relationship. Articles 9 and 12 of the Convention on the Rights of the Child concern participation and contact. The absence of a reviewable decision may prevent a timely challenge to the very arrangement shaping the family's relationship. [56]; [390].

Action, consequences, responsibility and demands:each contact period must be reconstructed from requests, visits, cancellations and reasons. The municipality must show the basis in force at the time and its remedial action. Courts and appeal bodies must address the specific errors raised and the original documentation. The demand is cessation of a documented restriction without legal authority, a current proportionality assessment and a specific plan to remedy the distance to which the authority itself contributed.

In the described notifications of violence, the issue of responsibility is distinct: the municipality awaited the police investigation without undertaking the required independent relevant assessment. The Z and Others and O’Keeffe tests in chapter 6.12 provide a human-rights basis for examining the lost opportunity to protect. The demands are actual protection of the child, preservation of originals and scrutiny of the receiving authority and management. Final proof of a crime is a different element from the risk triggering the duty to assess. [84]; [57]; [388].

8 Police and accountability oversight: from failure to protect to a weakened response

8.1 The citizen in the ditch: specific knowledge and failure to rescue

Conclusion: The police's own disciplinary summary describes an individual with Parkinson's who called after a bicycle accident and said that he could not get up. No rescue effort was initiated; the individual was found in a ditch after more than 42 hours. This is a direct and specific failure to protect line of inquiry.

The authority's statement: The Independent Police Complaints Authority criticised the conduct and found the action highly regrettable; the National Police's response was a warning. Original evidence of the full incident consists of the emergency call recording, log and rescue records, which are not attached to the summary. The summary is an official subsequent link in the source chain whose factual statements must be checked against those records.

Significance and rule: The reported helplessness gave the authority specific knowledge that had to be translated into a relevant protection assessment and action. The Article 2 test requires a specific risk to life and the relevant knowledge test; Article 3 requires, among other things, a sufficient level of severity of treatment. The failure to provide a rescue response and its duration must be examined under those conditions, not merely classified as poor service. ([49]; [54])

Consequence, responsibility and demands: Disclose who received the information, what decision was made, the reasons, possible rescue steps, harm and subsequent redress. A warning is a personnel outcome; it is not proof of effective investigation, sufficient individual reparation or examination of management's role.

8.2 Protection already fails at report intake

The 2007 summary, no. 11,describes a citizen injured by violence whose report was not registered and who was told to leave. The employment-related response was 800 kroner. The specific evidence is the summary; the contemporaneous report, duty log, medical information and decisions are the next source links. [99].

Failure to register may deprive a citizen of access to investigation and weaken the ability to document the authority's knowledge later. This is a deficiency in both protection and the evidential chain. Where the reported violence constitutes an arguable serious violation of rights, the duty of effective investigation must be examined even if the perpetrator was private.

Rigsrevisionen's May 2026 report on discontinuing investigations of offences against the person, and the ministry's September 2026 response, provide a more recent national line of scrutiny concerning, among other things, rape, stalking and human trafficking. An outcome involving discontinuance must be distinguished from a finding that every reported act actually occurred. The relevant criticism concerns whether reports were adequately investigated and closed on a lawful basis. ([78]; [81]; [79]; [110])

The requirement is to recover the identified cases, to investigate neglected protection needs and relevant investigative measures, and to record reopening and actual remedying. A new guide to the police cannot replace the assessment of cases already closed where danger can continue.

8.3 Incorrect attribution of interview reports

Conclusion: The 2006 summary, no. 15, describes how a superior wrote three interview reports and asked a trainee to sign as the interviewer. The reports were entered in POLSAS. Criminal proceedings under sections 155 and 157 were concluded without charges; criticism and a disciplinary fine of 800 kroner followed.

Discrepancy: The stated signatory was not the author or interviewer described. This weakens source identification and examination of who actually saw, heard and formulated what. It does not in itself document that all substantive information in the reports was false. The already documented authorship problem must be pursued without awaiting proof of another, stronger allegation.

Rule and consequences:the right to challenge adverse evidence requires an accurate source chain. Employment duties and the relevant Criminal Code provisions must be assessed against the specific action and culpability. Where the report forms part of criminal proceedings, the original questioning, dictation, corrections, signature and later judicial use must be connected. A judge’s later reference to the report is not independent confirmation of its origin.

Responsibility and demands: Investigate both the superior who drafted and required the signature and the organisational oversight of how the reports were created. Produce later case outcomes and assess whether the evidence's changed provenance requires reopening or another specific legal consequence. The management instruction must not disappear because the visible signature belongs to a trainee.

8.4 Illegal arrest and humiliating treatment

The 2007 summary, no. 31, describes use of police identification during a private dispute and arrest without cause. The response was a disciplinary fine of 800 kroner. The 2006 summaries, nos. 26-27, describe respectively a handcuffed detainee on the floor with a foot against the neck and a degrading toilet situation. In the summaries, the treatment was assessed as unnecessary, dangerous or humiliating; a fine and reprimand followed without the criminal prosecution described. [98]; [99].

These statements must be checked against incident records, use-of-force reports, medical findings, statements and any recordings. The legal test encompasses the legal basis for deprivation of liberty, the necessity and proportionality of the force used, and Article 3's separate severity threshold. The criticism in the summaries is not a Convention judgment already delivered.

The pointed question of responsibility is how the authority assessed continued service with the same intervention powers after an established serious breach of duty. The low fine is not alone evidence that the person subsequently repeated the action. The personnel case’s risk assessment, supervision, new incidents and actual continued performance of duties are the necessary evidence of a serial course.

8.5 Delay becomes a shield against accountability

In the 2011 summary, no. 61, almost four years of case processing led to a more lenient response to the employee under criticism. A report concerned the possible remand in custody of 45-50 arrestees; the number does not prove that all were actually unlawfully detained. In 2014, no. 32, a disciplinary recommendation was received after a year, and no disciplinary proceedings were initiated despite the National Police's description of the conduct as wholly unacceptable. [100]; [101].

Here the connection between time and response is specifically documented. The authority’s delay conferred an advantage regarding accountability, while it is not apparent that the consequences for citizens were investigated and remedied. Two independent questions must therefore be raised: the breach of duty in the original incident and the breach in the delayed assessment of responsibility.

The demand is a dated reporting chain identifying responsible roles, the actual reason for each pause and an assessment of whether delay cost evidence, opportunities for accountability or redress for the citizen. The oversight and personnel-control bodies’ own delays must not remain an unexamined residual area.

8.6 A register of persons is necessary for the strongest allegation of serial violations

The published disciplinary summaries cover official duties, private conduct and internal employment matters. A numbered entry may involve several employees or several responses, and the same employee may recur. The relevant evidence of a failure of accountability is therefore the specific incident, the established breach of duty, the elapsed time and the actual response. The examples above show disciplinary action weakened or omitted because of the authority's own delays. On their own, they do not prove a national frequency of repeated violations committed by the same employees. [100]; [101].

The decisive evidence for serial violations is protected person linkage: employee and manager; function and authority; event; date of awareness; response; continuing contact with citizens; new breach of duty; and the oversight body's knowledge before recurrence. Linkage must have a lawful data basis and may be published in anonymised form. Anonymising publications need not prevent competent oversight bodies from investigating recurrence internally.

Documented dismissals and criminal convictions in other entries must be retained in the accounting. They refute a universal immunity allegation. They do not refute the specific examples of weak responses, uninvestigated risk of continuation and accountability lost through delay. The criticism becomes sharper by showing precisely where the accountability system actually failed.

8.7 Legal evidence chain concerning the duty to investigate and lost accountability

Conclusion: The scope of the investigation and the authority's own delay must be examined as separate protection problems. Original evidence: in 2023, the UN Committee against Torture criticised Denmark's investigations of complaints against the police and their narrow focus on individual criminal guilt. The national disciplinary summaries describe specific proceedings in which almost four years of processing weakened the response, and in which a late recommendation resulted in disciplinary proceedings not being instituted. These are specific documented mechanisms; their significance for a particular serious abuse must be linked to the original case.

Relevant rule and departure: Articles 12-13 and 16 of the Convention against Torture and the investigative requirements of ECHR Article 3 concern clarification of relevant severe treatment. The decisive verification question is whether the investigation secured the material needed to examine the incident, necessity and responsibility. Closing a case solely because a named person's criminal guilt could not immediately be proved does not necessarily answer that question. For the serious violations covered, the effect of accountability on recurrence is also a separate international issue. [392]; [388]; [138].

The authority's specific statement closing the matter must therefore be produced with its reasons and the material actually examined. Emergency-call records, video, witnesses, medical records, use-of-force reports and instructions must not be replaced by a later institutional summary. If identifying a relevant officer became impossible because of the authority's documentation or inaction, that error must be included in responsibility for the investigation. An evidential deficiency created by the State itself is a specific ground for criticism, rather than an exoneration of the scrutiny process.

Consequence, responsibility and demand: The demand is verification of the serious incidents against original material, a timeline for each authority link and a reasoned assessment of continued service and risk of recurrence. For other breaches of duty, national accountability processes must be pursued in time. The Article 3 track applies where the nature of the treatment and allegation meets the relevant threshold; it is not an automatic reclassification of all disciplinary cases. Whatever the classification, the demand to remedy the already documented national breach of duty remains.

9 Healthcare and psychiatry: time-dependent rights, inaccurate measurements and shared responsibility

9.1 The right to diagnostic assessment was breached while registration could conceal the breach

Conclusion: The material documents extensive breaches of the right to diagnostic assessment in child and adolescent psychiatry and a practice in which the first meeting in three regions was registered as a completed diagnostic assessment. The latter is an independent oversight problem: an incorrect completion registration can make compliance with rights appear better than the patient's actual course.

Original evidence: The National Audit Office's investigation covered 42.252 referrals in 2019-2022; after 1.759 unfinished courses were excluded, the population used was 40.493. More than 27.000 courses exceeded 30 days. The average rose from 76 to 115 days. Referrals and courses do not necessarily represent unique children. The excluded group without an indication of completion must not be counted as documented compliance with the time limit. The register analysis of the 42.252 courses covers referrals up to the first quarter of 2022. The special suspension of the right to diagnostic assessment from 18. March to 1. September 2020 must also be included in the assessment of legality; the sample's assessments of rights violations excluded referrals from 16. February to 1. September 2020. Exceeding 30 days during this special period therefore cannot automatically be classified as the same breach of law as outside that period. [107]; [109].

Discrepancy and significance: Completed assessment and first contact are different events. If they are conflated, the oversight target is shifted without a corresponding change for the child. This is more serious than imprecise statistics if the entry is used to determine rights or answer criticism of waiting time.

Rule, action and departure: the right to diagnostic assessment under the Health Act then in force and information about other relevant options must be examined in the specific course. Capacity-related postponement and the lack of relevant information must be connected to the rights actually available to the patient. The authority's staffing problem is information about the cause of the failure; it is not in itself evidence that the right was fulfilled.

Consequence, responsibility and demands: Disclose the actual completion date, first contact, plan, information and treatment delivered. Correct both registration and the decisions it affected. Establish deterioration and other harm through clinical documentation. The region and relevant management must show when they acquired knowledge, how practice was corrected and whether correction was checked in new processes.

9.2 Follow-up continues to show serious delay

The follow-up in 2025 included 75 referrals from September 2024; 72 were delayed for capacity reasons, and 26 of 71 relevant information letters were insufficient. The average in the second quarter of 2025 was 162 days. The sample and denominators must be maintained; this is not 72 per cent or a count of all children in Denmark. [109]; [107].

The documented recurrence after the first review supports an allegation of insufficient remedial action on a known rights problem. A changed rights framework in 2026 does not automatically restore the diagnostic assessment time the child lost in 2024. The effect for the citizen must be documented through the actual course of events, not by the date of a new law or plan.

9.3 Psychiatric coercion: approved does not necessarily mean fully legal

The Patient Complaints Board's 2025 annual report states 4.093 points of complaint, of which 3.257 were examined on the merits. 419 were set aside. In addition, 96 were approved but recorded as formally unlawful. For 207 approved initial applications of compulsory restraint, the duration was approved in 103, set aside in 82 and not determined in 22. [51].

Conclusion: An overall approval rate can conceal independent instances of unlawfulness concerning formalities or duration. The legal assessment must be divided into initiation, continuation, formal safeguards and actual cessation. A lawful start does not provide legal authority for every subsequent duration.

The calculated sum 419 + 96 + 82 = 597 denotes adverse partial results in separate categories. It does not represent 597 patients or 597 independent whole cases. The duration fraction 82/207 includes 22 without a decision; 82/185 covers only durations actually decided upon. Neither is a nationwide figure for all coercive restraints.

Rule and departure: The conditions of the Mental Health Act, necessity, the least intrusive means, ongoing monitoring and appeal safeguards must be applied according to the time and nature of the intervention. Article 3 and Article 5 must be examined separately in relation to treatment and deprivation of liberty. Review must follow the specific conditions for intervention and Convention requirements; a general reference to medical necessity does not document that all conditions were satisfied. [45]; [51]; [49].

Consequences and responsibility: the individual patient’s timeline, ongoing monitoring, medical record, decisions and actual cessation must be verified. For each duration set aside, responsibility, harm and redress must be assessed. Subsequent approval of hospital admission does not answer the question of unlawfulness during the separate period of restraint.

9.4 Waiting for review and the particular harm it causes

In 2025,the average for cases with suspensive effect was 6,4 working days and for other cases 216,9 calendar days. The figures use different units. 216,9 days until a decision does not prove 216,9 days of continuing coercion. It documents a long time until a legal determination in that category. [51].

Waiting time must be followed through to the patient's access to evidence, record correction, compensation and protection against recurrence. For a brief intervention, coercion may already have ceased while the need for effective investigation and remedial action remains. For a continuing intervention, the significance of delayed review must be examined urgently and specifically.

The requirement is an overall chain of patients from intervention to complaint, termination, review, possible appeal, liability and payment. The 16 amended sub-decisions of 296 in 2025 may not be rewritten into 16 out of 201 patients or cases. The processing units are part of the evidence check. [50]; [51].

9.5 CPT: repeated warnings and improvements to keep local

The CPT material shows criticism in 2008, 2014 and 2019 of poor implementation or lack of progress on certain guarantees. It is a concrete international chain of knowledge. It must specify each recommendation, responsible Danish recipient, response and subsequent practice. [39]; [42]; [44]; [45]; [46].

In Aarhus, the reported number of restraints fell from 1.167 in 2022 to 569 in 2023 and 239 in January-May 2024. This is a documented local decrease across different observation periods; the last figure must not be treated as a full-year figure. At the same time, 33 restraints lasted more than 48 hours in 2023 and 17 in the subsequent partial period. 18 young people aged 14-17 were restrained 237 times during the stated period January 2023-May 2024. Repeated incidents do not amount to 237 young people.

A genuine local decrease must be included as a finding. It does not document that prolonged or unlawful interventions have ceased or that the remaining safeguard problems have been resolved nationally. The demand for improvement must therefore concern frequency, duration, necessity, safeguards, harm and subsequent accountability. A decrease in just one indicator does not discharge the overall duty to protect.

9.6 Relief lost while the case is going

In 2023,specialist palliative care met the contact-within-ten-days target for 79 per cent, against a quality target of 90 per cent. Average waiting time was 20 days, compared with 24 in 2019. The ten days are the stated quality target, not automatically an individual statutory deadline. [108].

The legal and human problem is dependence on time: assistance after death does not restore the relief that was not provided while the person was alive. The case history must therefore be measured up to actual contact and treatment, with deaths before the offer recorded separately. Legal characterisation requires the patient’s rights, known needs, available actions and the specific omission.

The 2006 course concerning delayed radiotherapy shows another time-dependent harm issue:the message received by the authority, postponement of treatment and assessed harm must be connected. The stated percentages for psychological harm and change in prognosis are assessments in the specific case, not a national harm rate or a Convention judgment. [94]; [95].

Demand: Establish the dates of recognised need, referral, a timely opportunity, actual treatment, deterioration and subsequent compensation. Failure to deliver and slow redress are two different failures for which responsibility must be assessed separately.

9.7 Adverse incidents and the narrow protection of the person reporting

The annual report records 489.361 reported adverse events in 2024:127.850 individually reported and 361.511 reported in aggregate. 6.010 were potentially fatal. Potentially fatal is not an actual death; reporting is not a legal finding of breach of duty. [120].

Section 201 of the Health Act protects against certain sanctions arising from the reporting itself. It protects a specific evidential and reporting basis. The provision is not general immunity from responsibility established on an independent basis. The relevant criticism is therefore to investigate whether the learning system is actually connected to necessary independent oversight of serious or repeated risk, and how affected patients obtain remedial action. [121].

In prison healthcare, the material indicates that Øst did not retain the described UTH information after handling it, while Vest reported 38 incidents, including 35 medication incidents, in April 2024-June 2025. This is a specific data-retention and comparability deficiency. It is not a calculated national number of harmed prisoners. [80].

The demand is documented learning, preserved evidence trails and an independent assessment of seriousness. The patient’s evidence must not become inaccessible because the incident has been organisationally marked as handled.

9.8 Individual complaint, compensation and professional authorisation must be linked

The Disciplinary Board received 371 new cases in 2025, compared with 4.253 in 2024. The annual report attributes the change to new triage into complaints about treatment courses and changed categories. The decrease must not be used as proof that errors suddenly almost disappeared. [122].

Disciplinary criticism, Patienterstatningen's decision and supervision of professional authorisation answer different questions. An accepted treatment injury is not always evidence of a criminal error. Disciplinary criticism is not automatically

compensation payment. A serious recurrence track requires linkage between decisions, healthcare professional, workplace, supervision, continued service and new incidents.

The demand is a verified chain from injury to complaint, criticism, oversight, relevant assessment of responsibility and actual payment. Compensation awarded during the year must not be rewritten as amounts paid during the year. Where publications do not state interest, actual payment time and deduplicated individuals, this information must be obtained separately. [91]; [93].

9.9 Aggerholm v. Denmark shows an adjudicated violation of Article 3

Conclusion: Denmark has been found to have violated ECHR Article 3 in a specific case of psychiatric coercion. In Aggerholm v. Denmark, 45439/18, judgment of 15. September 2020, the ECtHR unanimously found that the continued belt restraint was insufficiently justified. The official judgment press release describes almost 23 hours of restraint on 8.-9. February 2013. Its initial use was accepted; the deficiency concerned continuing necessity and duration.

The authority's and courts' statements tested against the evidence: the Danish courts had considered the intervention necessary. The ECtHR, however, highlighted inadequate reasons for continuing it after calm had been observed, a period at night without a medical risk assessment and an unexplained delay after the decision to end it. The specific discrepancy concerned the facts establishing current necessity. It directly exemplifies why prior national approval does not in itself verify the intervention's full lawfulness. [136].

Legal departure, consequences and responsibility: the violation of Article 3 is established in this case. For other courses involving coercion, the same distinction between initiation and continuation must be used to examine the original observations, decisions and actual cessation. A general patient description or an old dangerousness assessment must be checked against the relevant current situation. The report's demands concerning responsibility encompass the region's and treatment facility's management, ongoing oversight and actual learning from the documented errors.

9.10 Subsequent errors concerning duration require review of actual follow-up

Conclusion: The later Danish complaint findings show that the issue of unlawful continuation still required correction after Aggerholm. Original evidence: the Psychiatric Patient Complaints Board's 2025 statistics distinguish between initiation and duration. In the duration category for belt restraint, 103 were upheld, 82 set aside and 22 decided without a position being taken. These are decision units within this category and cannot be added to other categories as additional unique patients.

Relevant rule and departure: Aggerholm shows that the necessity of continuation must be examined separately. Articles 11 and 16 of the Convention against Torture make oversight of practices involving deprivation of liberty an ongoing preventive task. ECHR Article 46 concerns compliance with a final ECtHR judgment. The report makes no unverified statement about the Committee of Ministers' current status in Aggerholm; it requires production of the relevant follow-up records and evidence of their actual effect. [392]; [49].

Consequences, responsibility and specific demand: for decisions setting aside durations, it must be shown when the intervention should have ceased, when it actually ceased, what information those responsible held and what the error caused. Setting aside is a documented Danish outcome; its cause must not be assumed identical to Aggerholm without checking the originals. The region and oversight bodies must document correction benefiting the citizen, accountability and changed practice in subsequent cases.

CPT's documented fall in coercive interventions in Aarhus must be retained as actual improvement on the measured indicator. It does not remove the requirement to explain the remaining interventions' duration and lawfulness. A lower count and a lawful specific intervention are different measures. The report's criticism remains where later originals continue to show an error and ends on the specific point where actual improvement is verified. [45].

9.11 Psychiatric waiting time must be tested as a protection chain

Conclusion: Rigsrevisionen’s register and case-record review and the follow-up document a persistent problem with the right to assessment and actual waiting time. The excluded unfinished processes and the separate COVID suspension must be included in the legality assessment. The specific established rights violations outside the basis for exemption cannot be dissolved into an average or a changed administrative definition.

Rule, departure and significance: The Danish provisions on diagnostic assessment in force at the time must be linked to the specific referral and information provided. Article 24 of the Convention on the Rights of the Child and Article 25 of the Convention on the Rights of Persons with Disabilities are relevant international health provisions. Where the originals show a known, specific danger to life or a serious risk of treatment within Articles 2 or 3, the individual protection test from chapter 6.11-6.12 is also applied. Failure to meet the statutory deadline does not first require proof that these particular heightened thresholds have been met. [390]; [386].

Demand: Each affected course must show actual waiting time, information about rights, relevant alternative offers, interim protection, treatment and consequences. The political or administrative statement concerning improved capacity must be tested against these dates and outcomes. The continued waiting time in the follow-up provides a specific basis for demanding more than a new plan. The region must document the actual remedy for former and new patients.

10 Social services, disability and employment: the basis for assistance and the loss shifted to the family

10.1 Sickness benefit: decisions without current health information

Conclusion: The 2015 practice survey found 39 substantively incorrect decisions among 125 examined from 13 municipalities. Medical information was missing in 26; current information was missing in 22 of these. The deficiencies affected the factual basis for the decision on the citizen’s means of subsistence.

The authority’s statement and evidence: Those classifications appear in the practice study at the specific locators below. The original decision, case record and medical information obtained must be disclosed in an individual case. The missing-information category does not in itself prove which benefit the person was ultimately entitled to, but it proves an insufficient basis where the requirement was relevant.

Rule and departure from the law: the principle of ex officio investigation and § 10 of the Legal Certainty Act require sufficient clarification of the case. The benefit rule and follow-up duty in force at the time must be applied to the specific case. 29/125 had a delayed assessment under the relevant § 7 a; involvement was delayed in 23 and absent in 26. These particular duties must not be confused with the general municipal deadline under § 3. [97]; [32].

Consequence and responsibility: Lack of income support, waiting time, deterioration and loss must be linked to the specific decision and its errors. The municipality must show reconsideration, payment of arrears and actual support; management must show how the known absence of current medical information was prevented in new cases.

Demand: Annulment or amendment according to the specific error, obtaining the necessary documentation, a timely new decision and specified back payment or compensation on the relevant basis. A remittal without subsequent financial redress is not the whole legal consequence.

10.2 Resource programmes, flex jobs and pensions: classification must govern the allegation

The 2015 study of young people found 17 substantively incorrect decisions among 102. The first interview was delayed in 25; 52 had the described deficiency in the full interview, and medical information was not included in 14. These findings must be followed through each young person's case and the requirements then in force. [30].

The 2016 flex-job investigation found 42 substantively incorrect decisions among 130. The decisions examined were awards. The 2015 pension investigation found 16 substantively incorrect decisions among 78; all 16 were also awards, rather than refusals of pensions. The 29 refusals were assessed as correct in the investigation’s substantive classification, although procedural deficiencies were also found. These figures cannot be used to accuse municipalities of 16 documented unlawful pension refusals. [25]; [27].

The local numerical qualification does not change documented errors in investigation, guidance and procedure. The sustainable criticism is a decision-making practice that did not consistently rest on all necessary information and safeguards. Whether an individual lost a right requires the decision’s content, the conditions applicable at the time and the correct legal consequence.

A 2019 survey of pensions without consideration by the rehabilitation team found four substantively incorrect cases among 100 selected cases. Six of 14 young people had waited more than 18 months; one almost four years. The nature of the sample must be maintained. The historical rule on the team must not be presented as an unchanged current rule after subsequent reforms. [28].

The demand is to investigate where the time was spent, who knew the overall course, which information was repeated without an independent basis, and whether a fresh assessment actually led to assistance being delivered. A lengthy municipal course involving several levels of jurisdiction must be measured as one citizen course and also divided by responsible action.

10.3 Disability compensation and BPA: the name of the benefit is not its effect

De Retsløse describes Elsebet's experience with ALS, in which tube feeding was reclassified as a healthcare task even though the assistants had provided many meals over several years. The result was new dependence on nursing visits and uncertainty about the assistants' role. The book describes a municipal solution from January 2024, but also a lengthy wait for the appeal up to the book's account of the position in 2025. This is the author's published case narrative; the original decisions and treatment instructions have not been made publicly available. ([2], pp. 23-27)

The specific investigation chain is: actual task → jurisdiction and any delegation → social and healthcare legal responsibility applicable at the time → decision and reasons → changed provision of assistance → the individual's actual meals, freedom and safety → appeal → amendment or continuing loss. A quoted ministerial answer about who may generally perform a task is not by itself a binding decision on Elsebet's entire entitlement to BPA. It may be important counterevidence against a particular claim about jurisdiction and must be examined on that precise point.

The book also describes Mohammad, who has muscular dystrophy, inadequate practical assistance and later BPA following assistance from Muskelsvindfonden. The later assistance and participation in education are a reported actual improvement that must be included. They do not establish that earlier losses disappeared or that other individuals without comparable external support received timely assistance. ([2], pp. 29-31)

Responsibility must follow concrete refusals, needs and the basis for decision. The claim is individually justified compensation, practical assistance provided and the calculation of the burden that an unlawful omission moved to relatives. The survival of the citizen through the additional efforts of the family is not proof that the authority fulfilled its duty.

10.4 Dementia and use of force: a need for care does not automatically provide legal authority

The 2015 practice study covered 57 case occurrences from 13 municipalities; 30 were assessed as substantively incorrect. Individuals recurred across subgroups, so 57 is not a documented unique-person count. Relevant subgroups included six of seven instances of detention without the necessary basis and 21 of 34 delayed registrations. [31].

Conclusion: Serious documented deficiencies in legal authority and registration exist in an area where the affected person may have limited ability to complain personally. The purpose of providing care does not override competence, necessity, proportionality and documentation. A good intention is not the evidence required for an action restricting liberty.

The demand for each specific act is production of the decision, legal authority, current needs, alternative means, capacity to consent, actual duration, recording and supervision. The legal assessment must distinguish care, physical force and deprivation of liberty while also examining their combined effect. Relatives' and representatives' access to information and review must be stated.

10.5 Financial management considerations and responsibility higher up

The social workers' 2024 survey provides a specific lead concerning finances and senior management's wishes in decisions experienced as unlawful. The strong next step is to examine internal budget instructions, approval requirements, standard templates, performance targets and the handling of professional objections. Respondents' assessment is not an already verified individual order. ([47]; Bakkestrøm [3]; Kristensen [9]; Broberg [1])

If a binding individual right has been breached to meet a budget or an unlawful management instruction, this must be documented through the specific applicable rule and chain of decisions. Responsibility must not

is placed solely with the staff member who signed the decision if the manager ordered, approved or maintained the known unlawful practice.

A parallel line concerning the employee's lawful resistance must be investigated: professional warning, date, recipient, response, changed duties, reprimand or steps towards dismissal. Until these documents are available, a general risk of dismissal is a hypothesis. Once available, they can link the specific incentive mechanism to responsibility for the order and the citizen's harm.

10.6 Award without delivery: a new oversight point concerning the duty to provide services

Ankestyrelsen's own February 2025 statement describes the minister's October 2024 instruction to open oversight cases concerning the duty to provide services in five municipalities, and four opinions in December. The general opinion requires, as a starting point, immediate implementation of awarded assistance and rejects ordinary waiting lists without legal authority. The announced follow-up sample is a plan; its result must be produced. ([36])

Conclusion: A grant of assistance may exist while the individual still lacks help. Oversight of legal safeguards must therefore record the difference between a right on paper and actual delivery. The new aspect is that an authority may have made a substantively favourable decision and nevertheless continue an unlawful sequence of omissions by failing to implement it.

The demand is the award date, a lawful reason for any brief wait, the actual start, scope, absence and consequences. A case must not be called remedied by the decision if the service intended to remedy the failure is still missing. Management's knowledge of the waiting list and its capacity decisions must be linked to the affected courses.

10.7 A favourable decision without assistance is a separate issue of responsibility

Conclusion: A grant of assistance that is not implemented can leave the individual in the same situation without support that the decision was intended to remedy. The specific original evidence is the wording and date of the grant compared with delivery, the waiting list, follow-up and actual commencement. The documented provision and remittal processes in this chapter provide specific examples and avenues for investigation; they are not used as a national rate of harm.

Rule, action and departure from the law: the rule on benefits and provision in force at the time establishes the specific Danish duty. Article 2, paragraph 3, point c, of the ICCPR provides an express enforcement route where a remedy that has been granted concerns a protected treaty right. Articles 19 and 23 of the Convention on the Rights of Persons with Disabilities link support to independent living and family functioning. A purely domestic claim to a benefit must still be pursued directly, even though applying an additional treaty rule to the facts requires specific information about the right and the consequences. [391]; [386].

Consequences, responsibility and demands: the family must not invisibly assume a documented public duty to provide assistance. The loss must be described in terms of missing support, the period concerned, necessary out-of-pocket expenditure and other actually documented consequences. Management and oversight bodies must show when they knew of the delivery problem and how it ceased. The demand is actual delivery and relevant subsequent redress, rather than merely a new award or municipal commitment.

11 Other areas of public administration and scrutiny of the state’s own explanations

11.1 Personal data: a recommendation from 2005 was still not complied with in 2010

The Danish Data Protection Agency's 2010 report states that the Danish Commerce and Companies Agency had still not complied with a recommendation from 2005 concerning police access to a register via the internet. There were further significant IT security problems. This is a specific five-year chain of knowledge and follow-up that supports the report's criticism of oversight without turning all data complaints into established violations of the law. [48].

The authority's statement must be examined against the original recommendation, the agency's reply, technical access and later inspection. The rule is the data-protection law then in force and the specific security requirements. The documented omission is non-compliance with the identified order or recommendation, not an invented number of data leaks.

Responsibilities and requirements: Provide decision-making responsibilities, actual access, data use, known risks and closure. Following false personal information, its further use in other decisions must also be examined. Correction in one register does not necessarily solve the problem that the information has already created at another level of authority.

The Danish Data Protection Agency's annual reports distinguish between new inquiry and complaint files, notifications, inspection files and inspections actually carried out. These units cannot be converted into violations of the law or numbers of people. For example, in 2010, 78 new inspection files were opened, while 64 inspections were carried out; respectively, 11 new files and ten completed inspections concerned public authorities. An activity measure is therefore insufficient as a measure of whether known problems with citizens' rights were brought to an end. [48].

11.2 Tax appeals: the citizen's clock and the authority's clock are different

Landsskatteretten’s 2013 report stated an average of 9,46 months against a target of 8,5. It also described satisfactory professional results. The 20 percent target attainment measured contract points, rather than the proportion of citizens dealt with on time. For debt collection, the clock started only when the case had been fully investigated; certain periods on hold were excluded. [86].

Conclusion: The published measures may underestimate the citizen’s total waiting time and cannot alone document effective review. The significance of the evidence lies in the difference between statistical case disposal and the period during which a specific person bears a potentially incorrect claim, financial uncertainty or non-repayment.

The publication Tal fra Skatteankestyrelsen 2025 reports 10.577 closures: 2.746 favourable findings, 253 remittals, 4.606 upheld decisions, 235 decisions made more adverse, 698 other outcomes and 2.039 closures before consideration by the appeal body. The average was 13 months overall and 24,6 at the National Tax Tribunal. These closures are not unique taxpayers or collective proof of 2.999 original breaches of law; the basis for favourable findings and remittals must be coded. [114].

Demand: Connect the initial intervention, objection, appeal, stay, full investigation of the case, decision, correction of claims and actual payment with interest. Require reasons for periods without progress and a specific examination of access to an effective remedy under the applicable rules. Favourable judgments, concessions of claims and settlements must be recorded separately; a ministry's concession must not disappear from statistics that count only judgments delivered.

11.3 Immigration cases: a remittal is not a residence card

The Immigration Appeals Board's annual reports distinguish between overturnings, remittals, upheld decisions, dismissals and other terminations. The grounds for each remittal must be identified before an original illegality is counted. The board's own 2025 report also describes how procedural errors can be corrected during the board's consideration and how a decision can be upheld with criticism. An upheld decision therefore does not document an error-free original process; nor does a remittal document a subsequent residence permit or actual family reunification. [128].

Conclusion: An administrative closure metric does not document whether the individual actually obtained residence, a document, an opportunity to travel or reunification. A decision may also be upheld after correction of a procedural error; the outcome is not automatically proof of an originally error-free process.

The rule must be specified according to the type of case, including national law, relevant EU law and Convention requirements. In removal cases, the risk under Article 3 must be examined specifically; for family life, Article 8 and the relevant national conditions must be examined. A UN body's or international court's later consideration of the same case is a new oversight link, rather than necessarily a new person in the count.

The required record is the first application, documentation requirements, decision, grounds for remittal, new decision, actual card or permit, reunification date and all relevant interim decisions. A demand for comparative data must take account of the case's legal category and status; an ordinary average duration cannot automatically serve as the benchmark for a group entitled to special protection.

11.4 Stateless persons: the basis for orders, weakened warnings and continuing refusals

Conclusion: The Statelessness Commission's material documents practice contrary to the conventions, altered warnings in the internal submission, insufficient remedial work and a chain of responsibility in which the publicly available personnel trail for key managers ended long before citizens' civil proceedings. This is a particularly strong concrete example of the difference between the authority's closure and the citizen's redress.

Original evidence: Annex 18 to the Commission's report contains 50 individual refusal decisions relating to 44 different case numbers in the broader historical record. Within 2006-2025, there are 40 individual refusal decisions relating to 35 different numbers and five separate delay case numbers. The distinct union is thus 40 case numbers, not all 758 applications, which belong to a different population.

The authority's specific statement and discrepancy: The commission found that ordinary naturalisation requirements continued while a Nordic comparison was examined. It did not find it securely proved that the Minister actually understood the practice to breach the Convention at the relevant times. The uncertainty concerns precisely her knowledge. It does not remove the commission's documented criticism of practice, submissions and continued refusals.

Rule and action: Article 7 of the Convention on the Rights of the Child and the 1961 Convention's specific rules on stateless persons born in the territory could not be replaced by general requirements without the relevant examination under the conventions. In the remedial review, 27 of the 31 remaining potential cases were reopened in 2010; 23 led to the actual grant of citizenship in December, while four followed later. Others were not contacted until 2011. Reopening cases and granting citizenship are different outcomes.

Consequence and responsibility: Case 696 shows six months of further delay during the clean-up because old letters and requirements continued to be used. The commission criticised, among other things, advice to management, continued refusals and follow-up. In December 2015 and January 2016 the Ministry closed matters without further steps against the two central managers, who became kommitterede (senior advisers). These public decisions document closure and continuing public functions; they are not an independent disciplinary judgment. [116]; [115].

Demand: Examine who weakened the warning, decided to continue and accepted the incomplete corrective work. Disclose the specific assessment of responsibility and the subsequent risk analysis concerning continued service. The state’s responsibility for the practice contrary to the Convention must be addressed separately from individual guilt and from a compensation claim that subsequently became time-barred.

11.5 The civil review lasted over 14 years

The action brought on 10. July 2012 reached a High Court judgment on 28. May 2025 and a Supreme Court judgment on 21. August 2026. The stated judgment and filing dates yield 4.705 and 5.155 calendar days respectively. This is the duration of the litigation, rather than the same number of days without citizenship. The High Court trial had to be repeated because of judicial disqualification; the ministry received 50.000 kroner from the Treasury in connection with the repeated proceedings, while the claimants received no corresponding award on the grounds of legal aid and the absence of expenses of their own. Legal aid did not remove their additional waiting time. [131]; [74].

Højesteret's 22 appealing claimants received no further compensation. Four had an acknowledged possibility of earlier citizenship, but time-barred claims; nine had possible claims that would already have been time-barred; and for nine the court found no delay in the comparison used. The three different reasons must be retained. A limitation bar on an acknowledged delay claim does not exonerate the occurrence of the delay. [131]; [74].

The high court stated that the Ministry did not provide the requested comparison information from November 2021, but did not find that this changed the outcome. The missing disclosure is a specific evidential problem. It does not permit a rejected discrimination claim to be called judicially established. The demand is to examine, on a fully documented basis, whether the comparison used properly accounted for the special rights.

11.6 The instruction case: a general order could not replace individual review

The course of the instructions documents the separation of couples without the required individual assessment. The Court of Impeachment’s judgment of 13. December 2021 covered 18 couples under the original instructions; at least three were assessed as involving a substantive violation of Article 8 in addition to the procedural problem. The same unlawful period cannot be attributed to all 24 couples in the broader overview. Known periods ranged from seven to 228 days; three were not precisely established. [104]; [65].

Conclusion: This is a specific example of responsibility for an order that replaced the necessary individual assessment of protection and proportionality. Reopening in April 2016 after the change in March also shows that the date of correction and actual cessation are not the same event.

Rigsretten (the Court of Impeachment) found guilt by 25 of 26 judicial votes and imposed 60 days of immediate imprisonment. This is actual personal accountability, which must be included. It does not refute criticism of other accountability tracks, unresolved individual reparation or the time before correction. The demand is for a couple-by-couple account of the decision, separation, individual assessment, actual reunification and loss; the legal consequence follows each course of events, not the national headline.

11.7 Tibet: incorrect statements and insufficient evidence retrieval

The Tibet case documents unlawful interference with freedom of expression and assembly and later investigations that changed the official explanation of authorities' roles. The first investigation's statement and the later account to Folketinget are not two independent pieces of evidence if based on the same deficient source material. [126]; [127].

The later commission found further emails and a different chain involving the Ministry of Foreign Affairs and PET. Problems with name spelling and search identifiers meant that material treated as

missing, could be found through a more comprehensive search. This documents a specific deficiency in evidence retrieval. Without logs and originals, it does not prove that every missing email was deliberately hidden.

The commission's discussion of limitation and departures from office shows that late discovery weakened the possibility of personal accountability. The two suspended sentences in 2025 concerned false testimony in court in 2013; they do not constitute an overall criminal outcome for all original interventions. [126]; [127]; [132].

The demand is examination of original operational orders, sender, knowledge, intervention, subsequent explanation and search log. Closure must document both individuals' specific reparation and the system's ability to preserve and retrieve evidence in future. A commission report without these subsequent results is fact-finding, not the whole remedy.

11.8 Mink: known lack of legal authority and withdrawn personnel responses

Conclusion: The material on the mink case documents authority communications with the character of orders after knowledge of the lack of legal authority, and later accountability review in which several personnel measures were withdrawn. The two issues must be examined separately: the legality of the intervention affecting individuals, and each individual's official duty following the specifically delimited investigation.

Original evidence: The Commission connects the decision of 3. November 2020, the press conference, the Danish Veterinary and Food Administration's letter of 6. November and the police action card. At the NOST meeting on 5. November, the absence of legal authority outside the zones was discussed. According to the Commission, an amended action card of 10. November was not used; renewed contact was limited to some of the breeders originally contacted.

Discrepancy: A later description as encouragement or voluntariness cannot alone change the actual content of the letter and telephone script, including financial pressure and the prospect of culling by the authorities. The principle of legality and correct information must be applied to the communication the citizen actually received.

Review of responsibility: The published personnel notices identify five documented withdrawals concerning Barbara Bertelsen, Johan Legarth, Anne-Mette Lyhne Jensen, Uffe Stormly and Birgitte Buch. Fogde's separate inquiry covered four matters, not the action card itself. A result within that scope is not a decision on the legality of all actions affecting individuals. Non-publication of other closing decisions must not be rewritten as zero sanctions.

Demand: Produce the anonymised chain of actions and reasons, the factual premises that changed, and who had knowledge on each date. Connect individual contact, actual culling, the compensation decision and payment. Withdrawal of a warning does not itself remedy the loss caused by an actually culled herd.

11.9 Green Desert: the judgment-for-the-defendant label must not erase established ill-treatment

Højesteret found in favour of Forsvarsministeriet in 2022, but upheld the High Court's finding of inhuman treatment of 18 of the 23 Iraqi parties, including forms of torture. The ministry's general denial of ill-treatment was therefore not the judgment's overall evidential finding. The ruling in the ministry's favour concerned Danish responsibility under the jurisdiction, control and knowledge requirements applied. [75]; [52]; [66].

The ECtHR's 2025 outcome must likewise be divided into: dismissal of the substantive Article 3 complaint on jurisdictional grounds, dismissal of the investigative complaint, dismissal of the length-of-proceedings complaint for non-exhaustion, and a decision on the merits finding no violation of Article 6 concerning access and a fair trial. It is not a single substantive judgment that no one was ill-treated.

The document-verified criticism requires the original operational order, actual control and Danish reports on risk, detention and transfer. The available outcomes do not provide a basis for establishing Danish responsibility for torture without new evidence. They provide a basis for rejecting an authority's account that erases the 18

affirmative findings of abuse, and to demand precise examination of the specific chain of knowledge. The 2004 incident is historical; subsequent investigation and review fall within the report's period.

11.10 Samsam: the authority's denial formed part of a link later disproved

On 2. September 2025, the Supreme Court found that Ahmed Samsam had proved cooperation with PET and FE during the journeys in 2013-2014 and had received benefits. The judgment describes how the Spanish Supreme Court had attached significance to Danish information, including information about a Danish denial of cooperation. This is a specific discrepancy between the earlier authority-based evidential link and the fact subsequently established. [73]; [96].

Rule, omission and consequences:accurate information and effective review require examination of the original Danish response, SIS history and Spanish assessment of evidence. The Danish recognition judgment does not itself annul the Spanish judgment or establish that the entire deprivation of liberty was unlawful. Nor does it prove an intentional lie by a named Danish person without the original communication.

The demand is to secure the original chain, make the correct rectification, provide relevant assistance with specific reopening and determine documented losses. The 500.000 kroner in the Danish judgment were legal costs payable to the Treasury, not compensation for Samsam. Such a costs item must not be used as a claimed result of redress for the citizen.

11.11 Greenland: historical interventions and present-day reparation

The 2025 inquiry into contraceptive practices in 1960-1991 examined accounts from 354 women concerning 488 incidents: 410 involving intrauterine devices, 43 involving Depo-Provera and 35 other incidents. The sample was self-selected and included archival material; it is not a national random measurement or a judgment on each individual incident. The women and the incidents must not be conflated. [77]; [88]; [92].

Historical interventions are not included as new 2006-2025 actions. On the other hand, the subsequent knowledge, investigation, apology, arrangement and payment must be assessed as present-day actions. The same applies to the 22 Greenlandic children, where family ties and cultural ties were central.

The current examination must identify consent, age, actual treatment, harm and the relevant law at the time. Present-day reparation must be measured by the benefit received and access for all entitled persons, not solely by a political agreement or ceremonial apology. The special exemption from responsibility when obtaining documents under the compensation scheme, addressed in chapter 5, must be confined to its precise statutory scope.

11.12 Deprivation of liberty and slow redress

The reported average duration of remand detention increased from 3,3 months in 2018 to 6,2 in 2024. A group of 152 with acquittal on the principal charge had an average of 7,7 months. Acquittal does not automatically mean that every preceding day of remand detention was unlawful; each requires its own assessment of legal authority, risk and time. But the lengthy duration and subsequent access to redress are specific protection issues. [113].

The Suldrup case shows 875 days from acquittal to the decision on the compensation appeal and a correction of insufficient compensation. Another case shows pre-trial detention that exceeded the sentence subsequently imposed by 240 days, and a complete refusal of compensation by both the Regional Public Prosecutor and the Director of Public Prosecutions. The courts set aside the refusal and awarded 408.000 kroner plus interest. The High Court's decision upholding the award came 673 calendar days after release. [393]. The award date is not the payment date. [129].

The demand is to distinguish lawful remand detention, unlawful continuation, compensable harm, the duration of compensation proceedings themselves and actual payment. A person who has already lost liberty must not disappear once again into statistics of closed cases while financial redress remains unresolved.

Verification against the originals in the compensation course: release was on 12. December 2018, the State Prosecutor's refusal on 21. March 2019, the Director of Public Prosecutions' upholding of that refusal on 29. May 2019, the District Court's finding in the party's favour on 29. January 2020 and the High Court's judgment on 15. October 2020. The 673 days are calculated between release and the High Court judgment; they are not additional days of detention. The District Court's statement of facts gives release in 2019 in one place, whereas the attached contemporaneous administrative original gives 2018 and the time. The time calculation uses this original date. [393].

11.13 International criticism and enforcement are different endpoints

A final human rights judgment must be followed through to the individual and general measures under ECHR Article 46. Administrative closure of an execution case is an oversight outcome that must be assessed against the judgment's specific requirements, compensation and prevention of recurrence. The Green Desert proceedings provide a specific Danish chain of judgments culminating in the ECtHR's judgment of 21. October 2025, final on 21. January 2026. The judgment's own reasoning must be used; the number of international cases cannot establish a national victim count. [52]; [49].

The UN committees' concluding observations document repeated international warnings concerning municipal support, family life, psychiatric coercion, violence, disability and follow-up. These documents are separate from individual complaint decisions and are not person registers. Each positive finding and follow-up requirement is identified by committee, year, document number and paragraph. Several documents on the same course count as a chain of knowledge. [60]; [63]; [64]; [65]; [66]; [62].

The accountability demand is to trace each specific international finding to the Danish recipient, correction of practice, individual redress and fresh scrutiny. Denmark cannot use a completed payment as proof that another documented general problem has ceased. Equally, continuing open scrutiny does not automatically prove that every original act continues.

11.14 Compulsory access to the home: registration is not a check of legality

The directly verified report for 2024 states that there were 11 registered decisions on access to the home without a court order and no registrations in the separate category concerning police assistance when changing a placement location. All 11 were implemented on the same day. The figures are the municipalities' registrations, not independent findings of unlawfulness. ([15]; pp. 4-6 and 9-12)

The report's reproduction of § 139, subsection 4, requires necessity for assessing an obvious risk of serious harm and the parents' obstruction of less intrusive means. The municipality's response field on cooperation does not prove all these elements. The original basis and the actual intervention must be examined separately. Validated responses here mean fully completed questionnaires; this is not legal validation of the intervention.

The strong demand is verification of the decision, specific risk information, earlier less intrusive attempts, identification, actual access and subsequent review. Intervention without a court order is not automatically unlawful where legislation permits it. The specific criticism concerns any missing statutory condition and absence of independently documented oversight. The registration count therefore does not in itself document each decision's lawfulness. ([15])

11.15 Adoption from South Korea: historical involvement and proof of knowledge are different questions

Ankestyrelsen's memorandum of 10. September 2024 considers Udenrigsministeriet's historical material. It confirms Danish diplomatic involvement, including a request in 1976 to abolish adoption quotas. The agency assessed that the alleged bilateral adoption agreements had not been concluded and maintained its earlier conclusion. ([35]; pp. 1-2)

The precise source examination is: the original note → the specific information Danish recipients had → their action → possible risk or established illegality → later investigation and reparation. Diplomatic interest in more adoptions does not on its own prove that Denmark knew all subsequently documented illegalities in 1976. Conversely, the absence of a bilateral agreement does not prove absence of state involvement.

A specific allegation of Danish responsibility for unlawful adoption intermediation requires the original investigation records, the child's origins, consent and Danish recipients' contemporaneous knowledge. The published memorandum on historical diplomatic involvement cannot alone establish those evidential elements. The historical act must be dated outside the main period where appropriate, while Danish investigation, information, access to records and present-day redress form current duties.

11.16 Rare disabilities and brain injury: the individual assessment was missing

The 2015 practice survey covered 98 selected cases from 24 municipalities; 39 were classified as incorrect. In 34,there were decisive deficiencies in the factual basis, and in 20 an individual assessment was missing. The three error groups overlap. Selection followed the municipalities' knowledge of the target group and was not nationally random. [34].

This extends the social evidence line: a system can be familiar with a category of diagnosis without carrying out the necessary examination of the individual's support needs. Legal decision requires relevant functions, activities, participation, assistance and justification under the current provision. A standard estimate cannot be a substitute for the actual situation.

The demand is to show whether the established deficiencies in the factual basis were remedied, whether the new assessment changed the assistance, and whether the municipality checked for the same error in new cases. Commitments to greater knowledge of the diagnosis do not document an actual individual and lawful benefit.

11.17 Environment and equal treatment: the same scrutiny model with separate substantive rules

Equal Treatment Board decisions and published environmental scrutiny information provide separate documentary areas. Their complaint, annulment and activity units must be used according to their own definitions. They cannot be added to social-services cases to form one national count of unique individuals. [87].

An equal-treatment decision must be traced from the specific protected characteristic and treatment through causation, decision and actual compensation. The Equal Treatment Board's decision concerning a child's access to a music group shows 961 days to a decision; the payment date is not documented in the account reproduced. Lengthy proceedings and discrimination are separate grounds for criticism that must not be merged into an invented total loss. [87].

Environmental decisions require the original application, actual environmental information, consultation, relevant assessment duty, decision and any continuing activity after annulment. The systemic hypothesis must be examined through specific warnings received by the authority and its subsequent actions. Closure of a case without actual cessation of an unlawful activity may have the same oversight deficiency as other sectors, but follows its own substantive law.

12 The contribution of articles and books: human impact translated into documentable facts

12.1 Inhumane Case Processing and Justice Delayed Is Justice Denied

Ole Bakkestrøm's articles Umenneskelig sagsbehandling and Forsinket ret er nægtet ret formulate the report's fundamental citizen perspective: the decision's human effect and the time until a right can actually be exercised. The first addresses unlawful decisions, financial management, oversight and police; the second connects delay with duties of protection and review. These arguments are developed and supported by the specific original sources in this report.

This report carries the argument forward in a verifiable form: what was the citizen entitled to, from what date, what was actually delivered or implemented, and which authority created each time interval? The survey of police respondents discussed in Bakkestrøm [3] requires clarification: 13 per cent concerned respondents' participation in the described closures of cases despite obvious criminality and further investigative possibilities. It is not a figure for failures to register reports of crime. ([111]; Bakkestrøm [3])

The main argument in Forsinket ret er nægtet ret receives direct documentary support from the specific courses: more than one year without a contact decision open to review, delayed diagnostic assessment, prolonged compensation proceedings and assessments of responsibility weakened by time. The different timelines do not automatically prove the same violation of law. They show why time must be included in each argument's elements concerning conduct, harm and remedy. [84]; [100]; [74]; [129]; [53].

12.2 Resonance and loss of impact: participation must be able to change the basis

The article Resonans og tab af virkning itself defines its figures as explanatory teaching models. It expressly states that they do not prove unlawfulness, deliberate manipulation or shared intent. Its strong contribution is the distinction between being recorded and having a genuine opportunity to correct the factual basis of the case. (Bakkestrøm [5], pp. 1-8) [5].

The legal operationalisation is a document list: the individual's objection; attached original evidence; the authority's receipt; specific investigation; an amended or retained premise with reasons; the decision's legal consequence. If decisive counterevidence is not mentioned or examined, the criticism must identify that precise evidence and its significance. A friendly standard reply cannot replace that examination.

The model identifies a possible circuit: explanation → mention as conflict → repeated interpretation → weakened credibility → new decision on the same basis. That circuit is proven in a specific case when the dated originals show the movement and the decision-making importance. It is a model of investigation when the documents are still missing. The same institutional colour in an illustration is not proof of a conspiracy.

12.3 Resonance - when encounters have a regulating effect

Bakkestrøm [6] emphasises that resonance is neither agreement nor a favourable outcome. The concept describes an encounter in which relevant information can be received, examined and answered. It can support the report's demand for meaningful consultation of the party, investigation and reasons, but is not itself a legal rule. (Bakkestrøm [6], pp. 1-5)

The specific contribution is a quality requirement for correction: the authority must show what the new information changed, or the specific reason it did not change the assessment. Regarding timing and handover, the citizen must be able to see the responsible function, next step and completion. This human quality has

the importance of proof when its absence can be found in the absence of a response to a substantial objection or unclear decision-making power.

12.4 The human being as a rhythmic organism

Bakkestrøm [7] describes rhythm, pauses, responses, predictability and transitions as educational factors. The article itself states that the figures are not clinical models, diagnostic tools or proof of a particular cause. The report therefore uses the contribution to investigate everyday consequences, rather than to make diagnoses. (Bakkestrøm [7], pp. 1-6)

In a specific case, changes in sleep, meals, movement, contact, school, work, care and opportunities for recuperation are recorded. The citizen's own description is evidence of the experience described; records, a timeline and expert assessment must support medical causation and lasting harm. Unlawful action by an authority does not alone prove the cause of all later symptoms. The specific loss must be established, and a documented consequence must not be reduced to mere subjective dissatisfaction.

12.5 Systemic powerlessness and culturally conditioned dissociation

In Systemic powerlessness and culturally conditioned dissociation – when social culture conflicts with our natural rhythms, Ronnie Kristensen describes structures preventing people from responding to their own and others' needs, and a cultural separation between sensed need and external demands. The article is used as theory and a formulation of research questions, not as several independent empirical studies. [14].

The directly usable investigative question is whether the citizen or professional could make relevant knowledge effective:who knew the need, who could act, and what prevented action? Where an unlawful budget instruction is established, the obstacle is administrative and legal. Where powerlessness is experienced without the necessary records, the specific cause has not yet been established.

Culturally conditioned dissociation is used here as Kristensen's societal and theoretical concept. It is not a documented diagnosis among Danish public employees or a generally proven course of illness among all affected citizens. The report's criticism of accountability and scrutiny rests on specific records and does not depend on such a clinical extension.

12.6 When narcissism becomes powerful: check the retention of harmful behaviour

Ronnie Kristensen writes in When Narcissism Gains Power - and the Welfare System Loses Its Humanity (2025): "The most dangerous aspect of narcissism in the system is not one person with power. It is the culture that enables them to remain in power." This is a forceful thesis about institutional protection of harmful actors. The empirical questions concern documented conduct, management's knowledge and continued service. [13].

Sustainable criticism of authorities does not require proof of a personality disorder. It requires proof of conduct: altered records despite contrary evidence, an intervention on improper grounds, an omitted investigation, reprisals against a documented objection, management's knowledge and a continuing role permitting recurrence. This makes the article's central accountability question legally manageable.

If an institution knew of a specific serious risk and allowed the same actor to continue without relevant protection, this must be examined as a separate subsequent failure. The investigation must ask what risk was assessed, who was protected and how the next citizen was safeguarded. This is more precise and more accusatory than using a diagnosis as a substitute for documentation.

12.7 How Much Power: the Holstebro case and transfer of responsibility

Ronnie Kristensen's How Much Power Should Doctors, Caseworkers and Municipal Managers Have over a Person's Life? (2025) describes events in Holstebro in which, according to his account, support disappeared during the transition from the job centre to the social services department while the need continued. He describes a brief medical consultation, a disputed reclassification of support and treatment, an appeal and loss of access to a doctor. The article is a published line of witness testimony and argument. It does not in itself establish the contents of the original decisions, medical records or appeal outcomes. [9].

The strong case must follow known support before the pension, specific needs after the pension, the new competent department, application and actual delivery. An organisational transition does not prove that the need ceased. A medical certificate must be examined by reference to its questions, professional field, scope of examination and contrary evidence; it does not automatically gain greater weight because it is newer or written by a doctor.

The article's reference to ordinary case-processing deadlines under § 7 a is clarified as § 3 of the Act on Legal Protection and Administration in Social Matters; the express rule on the investigative principle is § 10. § 5 concerns the authority's broad assessment of assistance and options, rather than the same rule as § 10. Claims to a right to a particular treatment require the specific healthcare and benefit basis; proportionality does not in itself create a right to a particular prescription. ([97]; Kristensen [9])

Demand: The full transfer record, needs assessments, the legal basis of the decision, questions to doctors and their answers, consultation of the party, the appeal and assistance actually provided afterwards. Kristensen's presence at the meetings described provides opportunities for relevant testimony, but both his account and an authority's later account must be examined against contemporaneous originals.

12.8 When the body is silenced

Kristensen [12] criticises a narrow medical paradigm which, according to Kristensen's analysis, targets symptoms without sufficient attention to life context and relationships. The report carries this forward as a requirement to investigate whether the authority actually established the relevant social and functional circumstances. It does not adopt a universal claim that diagnoses or treatment cause citizens' suffering. (Kristensen [12], pp. 1-8) [12].

The specific evidence must show the question the statement was intended to answer, the factual basis, professional competence, alternative explanations appearing in the records and actual significance for the decision. An authority must not use a statement to prove a matter that the statement does not examine. A report on symptoms cannot automatically prove parenting capacity, support needs or the legality of a decision in another field.

12.9 When freedom disappears in the name of professionalism

Kristensen [11] criticises professional authorisation and supervision as possible restrictions on professional plurality and human contact. The actual new rules must be kept separate from this normative critical assessment. The Danish Patient Safety Authority's information on psychologist authorisation shows, among other things, a transitional arrangement until the end of 2028 for the relevant use of the title. The article cannot be read as proof that everyone affected lost the right to use the title or practise immediately in January 2026. ([119]; Kristensen [11]) [11].

The question of legal inquiry is a specific decision: legal basis, professional standard, supervisory documentation, consultation, proportionality and review. An alternative theory is not automatically illegal or professionally irresponsible; its documented use and the standard used must be indicated. Nor is a theory automatically clinically validated by being an alternative. Only the point that documents and rules can determine must be qualified.

12.10 Small-world: self-oscillation and organisational repetition

Ronnie Kristensen's Small World: reflections on self-oscillation, resonance, the human being as a mosaic of needs, and human development and winding down(2025) uses self-oscillation and resonance as explanatory concepts for human and organisational rhythm. The report uses the perspective for a specific feedback question: Can new information change the system's decisions, or does it merely lead to more of the same activity? [10].

The verifiable administrative pattern is a process of warning, plan, new error, new plan and continuing failure to verify the individual's outcome. The Langeland and barometer chains document relevant links. They do not prove a physical oscillation model of the state. The concept helps sharpen investigation of recurrence and missing correction, while decisions and actual practice remain the evidence.

12.11 The children have shown us this: quality measurement and concrete responsibility

Kristensen [8] draws, among other things, on the national daycare study. The VIVE/EVA publication checked directly reports good quality in 9 per cent, sufficient quality in 63 per cent and insufficient quality in 28 per cent of the educational learning environments examined. The sample comprised 185 groups in 100 municipal institutions from 56 municipalities. The result concerns municipal provision and the measurement method used; it is not a classification of the legality of all Danish kindergartens. ([130]; Kristensen [8], p. 1) [8].

The strong further application of the article is that a child's reaction must be examined in its actual context. The institution's conditions, known support needs, professional warnings and actual changes must be established before confidently attributing causation. The quality investigation does not on its own show that the institution caused each child's diagnosis. A specific breach of duty must be linked to a specific need and an action the municipality could and should have taken.

The demand is the institution's original measurement, action, follow-up and outcome for the citizen, together with scrutiny of whether evidence of poor well-being was reinterpreted as a personal deficiency without examining the conditions. A new form or programme is not an improvement until its actual effect is documented.

12.12 De Retsløse: the accounts as specific objects of investigation

The book brings together personal experiences concerning assistance, illness, disability, family and complaints. It states that some names are pseudonyms and that the identities are known to the editorial team. The accounts are relevant sources from parties and personal experience, but publication does not make them independently verified authority records. ([2], p. 7)

Elsebet and Mohammad are dealt with in Chapter 10. The other named chapters of the book about Helle, Sofie, Jane, the caring sister, Hanna, Karsten, Ira, Vera, Søren, Yasmin and Maya should be used to identify concrete needs, decisions, transfers, complaints and losses. They shall not be counted as new, documented breaches of law without the relevant file chain. The book's reports are listed together in the source annex, so no one disappears from the synthesis.

Christina's account contains a particularly important line of counterevidence. The book reproduces a telephone note in which a consultant child psychiatrist states that no attachment disorder has been diagnosed, that the mother is assessed as competent, and that the child has a complex neuropsychiatric condition. ([2], pp. 169-170) The reproduced wording "our assessment here is that the mother is competent, that she sees and hears M's needs" must be located in the original note, with its author, date and full context.

The legal chain is:the assessment and its basis→the municipality's later claim→any selection or omission→relevant statutory conditions→intervention and contact→consequence→responsibility.

A diagnosis in the child does not eliminate the need to investigate specific information of violence; the general experience of the doctor is not in itself proof that a specific statement was false. On the other hand, the doctor's specific statement of non-diagnosis and competent mother are substantial counter-evidence, which must not disappear in a later summary.

The book chapter’s statements about a general 99 per cent upheld rate, a mandatory parenting capacity assessment in all such processes and barred own-initiative action after every unanimous committee decision are not accepted as legal facts without the original rule and relevant population. Information about missing consent to record-sharing also requires examination of any other statutory authority and the scope of disclosure. These local limitations do not weaken the specific demand to disclose and address the identified medical counterevidence.

12.13 Magtmisbrug & Forvaltningskultur: the anonymised case patterns

In Magtmisbrug & Forvaltningskultur (2025), p. 3, Marie Broberg states that the book's cases are based on real accounts from case files received through work with families, with consent and anonymisation. This is the author's description of the sources. The accounts are treated as published documentation of the case pattern described and as specific leads concerning responsibility. An individually established breach of duty requires the underlying original records to be verifiable.

Case 97 describes a 14-year-old with severe anxiety and eight months of school absence, relevant professional documents and six months until the decision was upheld without the independent examination described. Case 98 reproduces reasons referring to KL guidance. Case 148 describes a 15-month process concerning a wheelchair and physiotherapy, with a remittal along the way, the municipal assessment maintained and assistance subsequently granted. (Broberg [1], pp. 172-173 and 261-263)

These cases entail specific evidential requirements: the original application and decision, every professional document, an objection actually considered, the precise legal consequence of remittal, municipal reconsideration and assistance delivered. A cited KL document must be located and compared with the law and the decision. The provisions of the Act on Legal Protection and Administration in Social Matters on appointments to appeal bodies describe several nominating organisations; they do not prove that KL controls every decision. ([97]; § 52)

Case 149 describes a child with ADHD and Tourette syndrome who lost almost a school year before a later favourable decision and support. It contains the incomplete statutory reference “§xx”. That reference is a specific gap in the book and is not copied as a valid rule. Education law, social support and respite care must be identified for each specific service and the original course of events. (Broberg [1], pp. 263-264)

The book cases must not be used as a random national sample or a register of unique victims. A case may contain several people; the same theme or person may recur. Annex A shows all identified case locations and local survey excerpts. Number 139 appears in two places and is retained with its location, so editorial numbering does not become a false person count.

12.14 Analytical method: documentation must be capable of changing the assessment

The report develops verifiable lines of argument concerning known errors, missing sanctions, reclassification, predetermined decisions and delay. Each line requires its own original evidence. A translation, summary or repeated analysis of the same corpus is a link in the source chain and does not count as a new independent investigation.

Institutional gaslighting is used to describe a documentable mechanism in which original counter-evidence is disregarded or rewritten while the citizen’s reaction is used to undermine their credibility. It requires a dated chain of statements, counter-evidence, the authority’s knowledge and

the significance of the decision. Experimental obedience percentages do not measure Danish public employees. The Convention against Torture’s specific conditions are examined concretely.

Source provenance, version history and separation of recommended from actually performed checks are the report’s methodological requirements. They do not automatically give an analysis greater legal evidential weight. The decisive question is whether the conclusion can be traced to an original document and every element of the relevant legal rule.

The overall principle is that each text has the evidential function its content supports. Articles explain and direct attention to particular mechanisms. Cases show specific investigative trajectories. Original decisions and records support the individual factual examination. Statistics and studies support their delimited systemic findings. No source category can automatically replace another.

13 Mechanisms that can make a known failure persistent

13.1 The next citizen: retention in service is a protection issue

In Gäfgen, the ECtHR found very lenient suspended fines insufficiently deterrent and raised serious doubts about a later appointment as head of the police technology, logistics and administration department. In its specific Article 3 context, the judgment highlights suspension during investigation and dismissal upon conviction in the practice described. It also criticises lengthy compensation proceedings. This strengthens scrutiny of the response's actual protective effect. ([55]; paragraphs 121-127)

The report's central Danish question is therefore not merely what sanction an actor received. It is whom the authority allowed that actor to encounter after the documented incident, which powers the person retained, what specific risk was known, and what effective safeguards were introduced. The demand must correspond to the documented conduct and applicable law; Article 3 case-law is not a general rule requiring automatic dismissal after every case-handling error.

Linking individuals can reveal whether an authority allowed repeated specific breaches of law to continue. It is particularly serious if management had already identified the actor’s approach or received professional objections. Responsibility for the new failure must be dated by the new act and the knowledge existing before it. Recurrence may thus create new responsibility for the authority, in addition to responsibility for the first incident.

13.2 Checking the same authority’s own explanation

When oversight relies on the criticised authority’s account, its central assertions must be checked against case records, the citizen’s information and actual follow-up. Rigsrevisionen’s oversight findings make this verification specifically necessary; the municipality’s response is not independent proof of its compliance. [106].

The problem becomes more acute if an authority first states that it has corrected a matter and the supervisory body then relies on that statement without documentation of the actual correction. This is evidential circularity: the same claim moves from municipality to supervisory body and back as confirmation by authority. The examination must identify the missing independent link and its significance, rather than merely count two official documents.

The demand is for the original decision before and after, actual delivery or cessation, the affected citizen's relevant contrary information and the supervisory body's reasoned assessment. A closure letter must explain which evidence supports the conclusion on lawfulness and redress.

13.3 Reclassification of decisions and actions

A substantive decision cannot evade review merely by being called guidance. A publicly organised relocation cannot become private through a label. Contact that is in fact supervised cannot become supported contact through a choice of words. A first appointment cannot become a complete diagnostic assessment through registration. The specific examples differ, but the evidential method is shared: examine actual substance, legal effect and competence. [84]; [107]; [127]; [73]; [69].

The decisive investigative step is to demand the precise decision, its legal authority, author and effect. If an outcome is rejected as not constituting an administrative decision, that boundary must itself be justified by its specific legal effect. Otherwise, the individual may be caught between an actual restriction and the absence of a reviewable decision.

13.4 The resistance of the citizen is used as evidence against the citizen

Bakkestrøm [5], Kristensen [9], Kristensen [13] and Broberg [1] describe a pattern in which objections become difficulty cooperating, documentation becomes overinvolvement, and crying becomes instability. This is a serious hypothesis that can be proved through a local chain of texts. It must not be decided solely by the individual's feeling of being distrusted.

Each link requires the original statement, its specific context, the authority's note, its subsequent reuse and the decision's reasoning. An accurate description that the citizen was angry does not in itself prove a lack of parenting capacity or a lack of entitlement to support. The relevance and strength of the evidence must be explained. Cases 32 and 33 in Broberg are clear published leads concerning how a note can be reused as a stronger characterisation with an earlier date; the originals are the next necessary evidence. (Broberg [1], pp. 92-93)

The demand is to remove documented incorrect facts from the decision-making basis, record the specific objection and reconsider decisions in which the characterisation affected the outcome. A rectification must reach every authority that actually used the information, on the relevant legal basis.

13.5 Management editing of professional warnings

The statelessness and Tibet cases document problems in presenting or retrieving significant information. Broberg's case 143 describes a PPR psychologist whose manager changed a description of anxiety and poor well-being to social challenges and justified the wording by the risk of costly measures. The latter is the book's account, rather than a named order checked against the original. [116]; [127].

If such amendments are documented in a specific case, both versions, amendment history, instructions, professional objections and use of the decision must be secured. The question is not merely whether a word was professionally possible. It is whether a relevant risk or support need was made less visible to change the action or avoid an obligation.

The requirement is an independent assessment of the responsibility of the manager who amended or maintained the information and verification of the decisions concerned. The employee's signature does not exempt from examining documented management orders.

13.6 The missing outcome register protects the system's self-description

Many public tables end at alteration, remittal, criticism or closure. They do not say when the child returned home, assistance was delivered, the patient received compensation, or the citizen's corrected information was used at the next level of review. The cited publications do not provide consolidated, person-linked documentation of redress. [33]; [84]; [36]; [91].

This gap prevents a complete national count of victims and consequences. It does not prevent demands for action in cases already identified. An individual is not required first to prove the scale of Denmark's entire problem. The requirement is that the state document fulfilment of the duty triggered by this particular case.

A public anonymised outcome register should show error type, responsible authority, original decision, first recognition, legal consequence, actual implementation, duration and accountability track. Linking people to recurrence must take place within the competent bodies. The register's own coverage and missing fields must be published.

13.7 The ability to complain becomes an unofficial access condition

The books describe the importance of relatives, support persons, lawyers and parent groups. Mohammad's case reports actual improvement following external assistance. This provides a specific line of inquiry into the difference between a formal right and practical access, rather than a national causal calculation. ([2], pp. 29-31; Broberg [1], pp. 157-161)

If necessary assistance arrives only after a prolonged specialist struggle, the authority must investigate individuals with the same needs but without comparable capacity to appeal. Such an investigation requires known relevant practice, the correct personal scope and legal authority to reopen. Substantively equal needs must not depend on relatives' endurance without a legal basis.

The demand is active identification of affected cases following a documented systemic error, accessible information, relevant procedural support and a specific redress decision. Those who did not appeal are not a group of demonstrably satisfied individuals.

13.8 The cost of the error is shifted while responsibility is fragmented

Failure to provide a benefit can shift practical care to the family, false information can shift the evidential work to the individual, and slow review can shift the loss of time and health to the party already affected. At the same time, the employee's financial liability may be limited and the authority's costs may fall within a public budget. This structure is relevant to incentives, but the specific loss must be documented. ([58]; Bakkestrøm [4]; Broberg [1])

A schedule of losses must therefore be prepared, covering lost income, additional expenses, care hours, missed schooling, lost contact, health consequences and work to obtain review. Not every item is compensable under the same rule. Each must have its own legal basis, cause and evidence. The authority may still be required to establish the overall actual consequence even where entitlement to compensation is narrower.

13.9 The formal response may have insufficient effect

A fine may have been imposed, guidance issued, a warning given and a commission appointed. The effect must be tested against the same problem: cessation, correction, reparation and recurrence. In serious ill-treatment cases, the effectiveness of investigation and response has particular human rights significance. For other duties of authorities, the examination follows the relevant rule. [55]; [67]; [100]; [101]; [118]; [58]; [127].

It is in this precise sense that the report criticises de facto protection from accountability. Not all avenues of accountability are empty; some are documented to be effective. The identified gaps remain when an avenue is closed without examining decisive actions, when time makes accountability impossible, or when the citizen continues to bear the loss after the authority's administrative closure.

14 Demands for cessation, redress, effective oversight and accountability

14.1 What must happen in the specific cases

The first requirement is the cessation or correction of the identified current unlawful act or omission. The competent authority shall specify the actual basis currently in force, including any other decision invoked for continuation. A new document shall not have retroactive effect as proof of an old act.

The second demand is independent renewed fact-finding on the original basis. All decisive objections and contrary evidence must be identified and specifically answered. The authority's earlier summary must be compared with the document it claims to reproduce. Errors must be corrected in the subsequent decision chain.

The third demand is actual implementation: assistance, lawful contact, relevant treatment, changed requirements, reunification where legally required or another correct legal consequence. The date, delivery, responsible role and any continuing deficiency must be stated.

The fourth demand is individual reparation with a legal basis and evidence of the loss. A distinction must be made between payment of arrears, damages, compensation for non-pecuniary injury, Convention compensation, interest, rehabilitation and practical redress. The amount awarded, actual payment and remaining loss must be separate fields.

The fifth demand is independent investigation of relevant responsibility. Employee, management, supervisory and State responsibility must be traced according to the specific duty. Where a possible criminal act is sufficiently documented, the report to the police must identify the action, original evidence, offence elements and evidence concerning culpability. Where evidence is still missing, the investigation must secure it rather than turn suspicion into an established fact.

14.2 The documentation to be provided by the supervisory authority before it finishes

The supervisory authority must state which specific circumstances it examined, which original records it checked and which citizen information it considered. Rejection or closure must have specific reasons corresponding to the material the supervisory authority actually received.

Where unlawful practice is known, compliance must be tested through actually corrected decisions and deliveries. A municipal declaration must be compared with the results. If a sanction or another power is not used, the relevant competence, statutory conditions and actual reasons must be stated. The report does not require automatic use of a power whose statutory conditions are not met; it requires a verifiable assessment of the documented circumstances. ([89])

Closure must include redress in affected old cases and review of new cases. There must be a separate point concerning employees or managers with repeated documented breaches of duty and protection of the next citizen. The absence of links to individuals in the public report must not make the question of internal responsibility disappear.

Jurisdiction and specific demand: §§ 47-48 of the Local Government Act establish legality supervision; § 48 a requires a decision on whether there are grounds to open a case, and § 49 permits information to be required. §§ 50 a-50 d contain separate powers of intervention. § 53 a permits the minister to examine Ankestyrelsen’s actions or omissions and require reconsideration; § 54 permits the minister to order that a matter be considered. [89]. The report demands a reasoned application of each relevant power to the documented information. Under § 48, subsections 2-3, the supervisory authority’s jurisdiction does not cover employment law rules or the field in which special appeal and supervisory bodies can decide the case. A legality problem affecting an individual and a personnel accountability track must therefore be referred to their respective competent bodies and followed through to the actual outcome. A jurisdictional boundary is not proof that the underlying risk has ended.

14.3 Lasting improvement must be demonstrated through practice over time

Lasting improvement is documented through comparable subsequent samples, requirements satisfied, the individual’s actual outcome and checks for recurrence. Oversight must cover unfinished processes and individuals who did not appeal where the relevant sample requires it. Completed delays alone conceal people who are still waiting.

No time-limited measurement can prove that errors can never recur. The documented duty of the authority must therefore not be declared discharged for all time on the basis of a single inspection. The requirement is enduring effective protection and a continued response when new information reveals a risk. A political declaration of permanent improvement must have a measurable and continuing basis of scrutiny.

14.4 Responsibility for unlawful orders and the continuation of practices

A manager must be assessed in relation to their own order, approval, alteration of warnings, failure to carry out checks and continued use of a practice known to be unlawful. An employee must be assessed according to their own conduct, powers, knowledge and duty. The evidence must preserve the relationship between the order and its execution, without automatically assuming that one person's culpability follows from the other's.

Where a specific threat of employment consequences is made in response to lawful professional resistance, the original communication, employment-law status, professional objection and actual response must be produced. The relevant whistleblower or employment-law protection must be identified on the basis of the disclosure and the person's situation. A general reference to loyalty cannot establish the lawfulness of an unlawful order.

Following a documented serious breach of duty, the authority must show how continued service was assessed. A transfer to another municipality or department does not in itself demonstrate that the risk has been eliminated. The same relevant powers exercised in a new setting involving contact with citizens may perpetuate the known risk.

14.5 Preservation of evidence and access to information

Requirements concerning original documents include version history, correction logs, sender, recipient and time, rather than merely the latest printout. Search logs must show the identifiers used, name variants, relevant accounts and retained archives. The Tibet material documents why an unduly narrow search can create a false impression that evidence does not exist. [126]; [127].

Missing or deleted documents must be recorded as a separate issue concerning documentation duties, archiving and the possibility of effective review. The absence of a document is not automatic proof of deliberate deletion. Nor may it be used as a self-confirming argument that the act described by the citizen did not take place.

The individual party's access must be examined under the applicable rules on access to documents, records and data protection. A legitimate exemption must be specified concretely and distinguished from the factual assertion that the authority seeks to prove using the withheld material. The opportunity for review and any confidential scrutiny must be described.

14.6 National accounting for redress and scrutiny of practice

The State should publish a coherent anonymised account of known systemic errors: the authorities and years concerned; the number of decisions by error type; the deduplicated number of people affected where legally possible; reopening; actual correction; delivery; payment; duration; and the outcome of accountability proceedings. The register must make the remaining group visible and retain changes in statistical definitions.

It should also show where current oversight proves improvement, where improvement has merely been announced, and where continuing errors have been found. There must be a trail for documented management knowledge and for follow-up that was not carried out. This is the necessary basis for determining whether a prolonged improvement effort has actually protected citizens.

14.7 Requirements of international law which can be translated into concrete action

Demand for cessation:all identified ongoing interventions without legal authority must be ended through a competent decision, and acute documented risks must be assessed immediately. The demand follows the specific right and rule governing intervention. A later overall investigation must not delay protective action where its basis already exists. For each case, the responsible recipient, decision, time limit and actual effect must be reviewable.

Demand for redress: The relevant old cases must be identified by error type, sample and known continuation, not solely by who still has the strength to complain. Access to records, a correct factual and legal basis, contact, support, cessation of interventions, relevant compensation and rehabilitation needs must be recorded together with actual outcomes. Each form of reparation must be justified by the documented right and harm. The report demands coherent implementation in which one body cannot close a case solely on the basis of another body's assurance.

Demand for an independent investigation: For the serious violations of integrity covered, the event, treatment, responsibility and oversight failures must be investigated using relevant originals. Management's warnings and instructions must be included alongside the frontline employee's act. The investigating authority must demonstrate institutional and practical independence from the case investigated and state which decisive evidence it has secured. A refusal must explain the specific deficiency, rather than reuse the criticised authority's narrative as evidence.

Demand for protection against recurrence: New incidents involving the same actor must be linkable by competent oversight bodies with proper personal-data protection. Known serious recurrence requires a specific risk assessment, relevant protective measures and responsibility for a management decision to retain the person in their role. The special international requirements concerning state employees criminally accused of ill-treatment appear in chapter 6.17. For other breaches of duty, competent national disciplinary and management review must proceed without abandoning protection of individuals.

Demand for follow-up of judgments: Aggerholm and other relevant adjudicated Convention violations must be connected to the State's follow-up records, specific changes and later oversight findings. The Committee of Ministers' documents must be obtained before drawing a conclusion on current execution status. A recorded international closure must be examined within its own scope and cannot serve as a general certificate for all later interventions. Current Danish duration errors require their own remedial action. [136]; [49]; [51].

Requirement for international documentation: A submission to a relevant treaty body must identify the specific right, the victim or documented systemic information, domestic steps, remaining violations and the remedy sought. For an individual complaint, admissibility conditions, deadlines and exhaustion of effective domestic remedies must be checked under the chosen body's rules. A comprehensive report does not replace this information. However, the international responsibility claim must not be postponed indefinitely if domestic remedies demonstrably fail to provide effective protection; the precise exception test must be made using the case records.

15 The overall conclusion on responsibility and the strongest arguments

15.1 The documented charge

The material as a whole supports a direct accusation against child and family administration, social and disability administration, employment administration, psychiatric assessment and coercion, and police and supervisory oversight of persistent failure to provide adequate protection and oversight. The tax and immigration appeal processes document extensive corrections of individuals' legal position, and the healthcare complaints system shows extensive criticism of healthcare professionals and treatment facilities. Over twenty calendar years, the state and municipalities have repeatedly received specific information about serious errors. New studies have found failures in fundamental safeguards again. In significant documented sequences of events, oversight has been able to conclude without proof of actual redress, and in specific accountability cases, the time taken by the authorities themselves has weakened the response directed at individuals.

This is not an unexplained administrative mishap. It is a documented problem in a chain of decision-making and protection that has repeatedly known of the errors without documenting their effective cessation. The chronology is particularly strong in children's services. In specific police, health, citizenship and oversight matters, knowledge, omission, time and inadequate closure are identified separately. The authorities' own statements about scrutiny must be tested against the findings they themselves published and against original records.

The strongest sustainable formulation of the immunity theme is a documented combination of special exemptions from liability, limited personal financial liability, narrow avenues of accountability, weak or lapsed responses and continued public service after significant criticism. These specific mechanisms can protect the responsible actor or institution from tangible consequences while the citizen's loss continues. A general assertion of lawful immunity for all employees would be weaker and incorrect.

Where the same actor demonstrably continues serious breaches of duty after management becomes aware, the criticism must move from individual errors to maintaining a known risk. Responsibility must be demanded of the manager or oversight authority that allowed the risk to persist. National person linkage is necessary additional evidence, not a prerequisite for criticising the specific documented failures of protection now.

15.2 Prioritised sustainable arguments

1. Known and repeated failures of safeguards. Historical child-welfare investigations and more recent independent case samples document recurrence of central problems after the authorities had acquired knowledge. Demands: specific cessation, reconsideration of affected cases and verified changes in practice.

2. Missing valid legal authority for intervention or competence. Where necessary consent, a competent decision or substantive legal authority is actually missing, the action itself must be assessed as an unlawful intervention. Demands:cessation of the specific unlawful arrangement, prompt review and redress.

3. The supervisory body's own insufficient follow-up. National findings and Langeland's specific chain of knowledge support scrutiny of the oversight decisions, their documentary basis and the choice of response. Demand: renewed verification against original records, a reasoned examination of competence and actual redress.

4. Failure to protect against a known specific risk. The emergency call from the helpless citizen and the described notifications of violence are specific traces of knowledge. Demands: investigation under the right's own knowledge and risk test, and responsibility for the identified omission.

5. Effective review prevented or delayed. Absence of a reviewable decision, a lengthy complaint process and late consideration of compensation must be assessed across the whole case. Demands: a specific decision, suitable interim protection under the rules, progress and effective remedial action.

6. Incorrect or circular evidence chains. Authorship errors, misleading registrations and central authority information later disproved require examination of the originals. Demands:rectification, reconsideration of the outcome and responsibility for the specific information.

7. Redress is concluded on paper. Remittal, a grant of assistance and an award do not document actual help, return home or payment. Demand: implementation date and verification of the remainder of the individual’s loss.
8. Personal accountability weakened by the authority’s delay. The specific disciplinary and commission proceedings show lost opportunities for accountability. Demands: separate investigation of responsibility for delay and preservation of evidence.
9. A known actor posing a risk is retained. When identity, recurrence, knowledge and continued service are documented, the new failure of protection must be raised separately. Demand: competent risk and responsibility assessment and relevant protection of subsequent individuals.

10. Management responsibility and unlawful direction. Professionals' information about management pressure must be traced to specific instructions and decisions. Demands: verification of the order, professional objection, financial purpose and actual accountability higher up.

15.3 What a satisfactory conclusion requires

The authorities must document that each identified violation or breach of duty has ceased, relevant assistance and redress have actually been delivered, responsibility has been examined on an adequate basis and the known risk of recurrence is met by effective scrutiny. Private records not yet established must be obtained for the individual allegations; national links to individuals that are missing must be supplied for the accounting of recurrence and consequences.

A summary of initiatives cannot support a conclusion that a problem has been solved. The state must answer the specific findings, documented knowledge and remaining loss. Where this has not happened, the documented issue of responsibility remains open, and criticism of continuing inadequate protection must be maintained at its full evidentially sustainable strength.

15.4 Massive systematic failure in the implementation of protection

Aggregate record total – gross sum of selected oversight and correction records from 2006 to 2025: 202.870.

The separate documentation concerning children is more direct about actual unlawful practice: five historical practice surveys record at least 361 case instances containing errors among 571 examined. The Child Welfare Case Barometers for 2020–2024 record 4.459 deficiencies concerning five central statutory requirements in 3.629 case instances examined. At least 1.446 case instances in these five samples have one of the measured deficiencies. The figures have their own denominators and must not be added together as unique children or added to the overturnings on appeal. The National Audit Office’s subsequent investigation finds at least one measured breach of law in 69 per cent of 3.148 first placement courses from 2022–2024. This shows that the problem continues in cases that have not been appealed and in the actual protection of children.

The verified international count comprises 24 distinct ECtHR proceedings with a finally established Convention violation among judgments delivered in 2006–2025, counted by final status as at 11. October 2026. It also comprises 57 favourable Views on the merits from UN treaty committees: 23 with an expressly established violation, including three with an additional forward-looking protective finding, and 34 with purely forward-looking or conditional protective findings. Added to this is a separately established Article 22 procedural violation in the F.K. case.

The European decisions concern, among other things, the length of proceedings and effective review, freedom of association and expression, discrimination and family reunification, deprivation of liberty and psychiatric coercion, expulsion and children's private lives, investigation of rape reports, and use of force and protection of life in prisons. The UN findings concern, in particular, protection against torture and abuse upon removal, protection of children, discrimination, family life and psychiatric coercion. These are separate categories of decisions and findings; no consolidated count of unique victims is derived from them.

The sector-specific annual tables and the precise unit of counting are set out in chapter 2.7–2.17. The count makes the continuing scale of oversight visible and maintains the distinction between domestic decisions setting measures aside, criticism, correction and an internationally adjudicated violation. It must be followed through to the specific authorities and their responses; the form of the count provides no justification for failing to provide redress.

The strongest overall conclusion is that Denmark has experienced massive and systematic failures in child and family administration, social and disability administration, employment case processing, psychiatric assessment and coercion, and police and supervisory oversight, and that the state has allowed known problems to recur through new generations of cases. In the children's field, the chronology from 2006 to the new review in 2026 supports a twenty-year accusation of knowledge and recurrence. In psychiatry, the adjudicated Aggerholm violation, later decisions on duration and the assessment review support separate accusations of failures of protection. The study of supervisory responses and Langeland's specific case document that the problem also lies in the implementation of oversight.

The conclusion concerning the massive scale is supported by the specific findings: 69 per cent of 3.148 new placement processes with at least one measured breach of law; deficiencies in safeguards in all 77 Copenhagen cases examined; substantial documented assessment delays; and continuing breaches of limits on the duration of coercion. The national systemic significance is supported by different periods, new samples and specific decision-making and oversight chains. The figures are not added together to produce a national number of victims. Each field's scale and evidential status are retained.

The conclusion concerning positive obligations is supported by the connection between the findings and the function of the right: failure to assess protection in the face of a specific risk; insufficient participation and an insufficiently current factual basis for interventions in family life; unlawfully continued coercive intervention; insufficient investigation of severe treatment; and remedial action that is not followed through to actual implementation. ECHR Articles 1, 2, 3, 5, 8 and 13, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities and the ICCPR identify the relevant obligations. Chapter 6 and the evidence chains for the individual areas show which links are documented and which require the originals from individual cases. A procedural safeguard serves a rights-protection function; it must not be dismissed as a technicality when its absence weakens protection and review.

Rights violations already adjudicated must be stated clearly. Aggerholm establishes a Danish violation of Article 3. The Court of Impeachment's judgment in the instructions case establishes the adjudicated breach of ministerial duties and the stated Article 8 problems in the specific separation courses. The other review findings are not, for that reason, all individual ECtHR judgments. The report's systemic legal conclusion is its verifiable analysis of the documented actions and deficiencies. The authorities must answer this analysis by reference to the specific originals and duties. They cannot reduce it to the fact that only some of the courses have already been adjudicated internationally.

15.5 Protection from accountability also concerns the next citizens affected

The immunity theme has a documented core: an unlawful, institutionally accepted exemption from record-keeping, narrow accountability tracks, limited personal financial liability and specific losses of accountability through the authority's own delays. These are different mechanisms, not one general statutory immunity. Their common significance is that an unlawful act may receive insufficient individual or institutional follow-up while the consequences for the citizen persist.

The sharpened charge arises when the first breach of duty, management's knowledge, maintained function and a new relevant event can be followed in the same personal and decision-making chain. Then it is not only the first practitioner, but also the proven failure to protect against repetition, which must be tested. The report shall require the necessary interconnections with competent independent control. The lack of a public register as a whole cannot be used as a justification for omitting this specific study.

The official obedience structure and documented negative reactions to lawful speech reinforce the need to trace responsibility to management. Rules on a subordinate's responsibility cannot be turned into the termination of the State's or decision-maker's protective task. For serious violations, the connection between investigation, accountability and prevention of recurrence was expressly described internationally as early as 2004 and in Gäfgen in 2010. The international-law assessment is therefore whether Denmark secured effective protection, and what the documented oversight and management decisions actually did.

15.6 Denmark's international responsibility requires a citizen-oriented response

The State's international responsibility may encompass both the original action and later independent failures to investigate, protect or remedy. The specific treaty violation must be identified, and attribution traced to the Danish public function. Municipal or regional organisation does not change the bearer of international responsibility. For private services, the public omission constitutes its own avenue of responsibility. The report's conclusion is therefore not merely organisational criticism; it is a demand to fulfil the rights the State has undertaken to secure.

The response required is concrete: to stop proven unlawful continued intervention; to provide the protection and support required by the duty shown; to carry out independent relevant investigation; to remedy proven damage; and to verify protection against recurrence in new cases. General State responsibility and the individual basis of the Convention set out the framework. A national rule on liability, a public apology or a new action plan cannot in itself demonstrate that these links have been met.

In the event of serious breaches of peremptory norms of international law, special international legal consequences may be relevant. The report's various failures of legal safeguards must not be grouped under this category without a separate assessment of the applicable norm. Likewise, R2P and Article 7 of the Rome Statute are separate legal characterisations with their own requirements. The specific evidentiary gaps are identified in chapters 6.23-6.24 and chapters 17-18. This delimitation exempts no one from the already documented Danish breaches or the strong human rights allegation concerning protection.

The final allegation is that, throughout the documented period, Danish authorities have known enough to be obliged to provide much more effective protection, verification against original records and redress than the examined courses of events show. In the children's sector, new extensive breaches of the law have been established after twenty years of known problems. In psychiatric coercion, a Danish human rights violation has been adjudicated, while subsequent errors concerning duration still require correction. Where oversight has allowed a problem to persist without documented cessation and remedial action for the citizen, responsibility for the continuing omission remains unresolved. It must be examined and remedied through the specific demands in chapter 14.

16 Documented errors and precise evidence status

F01. Historical child-related errors and later repetitions. The specified studies show shortcomings in the basis and guarantees of new cases from different years. The documentation bears institutional knowledge and repetition; it does not identify the same staff throughout the period. [16]; [17]; [18]; [29]; [26]; [112].

F02. Deficiencies in all 77 Copenhagen children's cases examined. The combined set concerns at least one of the deficiencies examined, with different denominators for different themes. It does not document that all 77 placements lacked substantive legal authority. [84]; [71].

F03. Contact that was actually supervised described as supported. Six of 16 relevant arrangements in the Copenhagen study had this discrepancy. The actual intervention must be examined against a decision by the competent authority. [84]; [71].

F04. Consent under pressure and changing grounds. The identified twin and foster-family courses contain specific accounts of records concerning pressure, a changed form, public organisation and missing contact with parents. Final individual legal characterisation requires the specified originals. [84]; [71].

F05. More than a year without a formal contact decision despite requests. The documented deficiency is a decision and access to review, not zero actual contact throughout the period. [84]; [71].

F06. Lack of independent investigation of safeguarding notifications concerning violence in the cases described. The recorded notification documents knowledge; whether the violence actually occurred must be examined separately. [84]; [71].
F07. Repeated Langeland findings and insufficiently documented redress. The multi-year supervisory and task-force chain ended in demands for a fresh examination of legality, responses and reopening in 2026. [123]; [76].
F08. Oversight's documented weak follow-up and unused enforcement powers in the 2018-2024 investigation. The population and the zero-use finding for four powers must be retained. This is not a zero for all punishments or personnel cases in Denmark. [106].

F09. Failure to provide rescue after information that a person was helpless. The public police summary describes more than 42 hours before the citizen was found. Characterisation under Articles 2 and 3 requires the specified assessment of the concrete risk and severity. [102].

F10. Unregistered report of violence and incorrect authorship of interview reports. The specific summary entries document the described intake and authorship deficiencies. They do not prove falsification of the contents of all reports. [98]; [99].

F11. Assessment of responsibility weakened or omitted because of delay. Summary 2011, no. 61, and summary 2014, no. 32, expressly identify a connection between time and response. [100]; [101].

F12. Unlawfully accepted exemption for missing record-keeping. The Ombudsman's 2010 case documents the described practice over several years and its narrow factual context. It does not prove unchanged continuation after 2010. ([67])

F13. Extensive breaches of child psychiatric assessment deadlines and misleading registration of completion. The process unit and the exclusion of unfinished processes must be retained. Later follow-up shows continuing serious delay. [109]; [107].

F14. Psychiatric partial decisions involving setting aside, procedural unlawfulness or unlawful duration. Initiation and duration involve different reviews; approval does not necessarily mean full lawfulness. [51].

F15. Social-services and employment decisions based on inadequate investigation. The specified practice investigations document deficiencies in medical information, individual assessment and relevant safeguards. Awards must not be rewritten as refusals. [32]; [30]; [25]; [27]; [34].

F16. Unlawful or inadequately justified use of force in the dementia material examined. The 57 case occurrences are not 57 unique individuals. [31].

F17. Failure in 2010 to comply with a recommendation from the data protection authority issued in 2005. There is a concrete five-year chain of knowledge. [48].

F18. Citizenship practice contrary to the Convention, insufficient remedial work and altered warnings. The commission's assessments, individual decisions and later litigation groups must be kept separate. [116]; [115].

F19. Unlawful separation brought about by an instruction and an actual sentence from the Court of Impeachment. Substantive and procedural Article 8 findings, as well as the different couples and time periods, must be retained. [104]; [65].

F20. Tibet interventions and subsequent discovery of an inadequate evidential basis. Deficient searches, changed explanations and limitation barriers are identified. Intentional concealment of every document has not been established. [126]; [127].

F21. Mink-case communications after a known absence of legal authority and documented withdrawals of personnel responses. The delimited accountability case cannot determine the lawfulness of every act towards citizens. [72]; [117]; [83]; [82]; [103]; [70]; [90].

F22. Samsam’s subsequently established cooperation is incompatible with a central earlier authority-based evidential link. The judgment recognises that cooperation; it is neither a quashed Spanish criminal conviction nor a Danish compensation decision. [73]; [96].

F23. Unlawful disability discrimination in music provision and a long time to decision. An award of compensation and actual access or payment are different endpoints. [87].

F24. Incorrect compensation outcome following deprivation of liberty and lengthy compensation review. The specific judgment and date information supports the criticism; actual payment and complete redress are not documented by the judgment amount alone. [129]. [393].

F25. Deficiencies in public documentation of actual implementation and person linkage. The identified source extracts do not provide a full national chain from error to the citizen's life. This is a delimited data gap, not proof that every missing item of information never existed internally. [33]; [84]; [36]; [91].

F26. Negative management responses to lawful public statements. FOB 2019-2 and FOB 2026-4 document delimited errors concerning meetings, reasons and the first correction. Later follow-up in the teacher's case is included. [134]; [135].

F27. Danish Article 3 violation through continued belt restraint. Aggerholm v. Denmark, 45439/18, judgment of 15. September 2020, establishes a specific Convention violation. The initial application and the insufficiently justified continuation are kept distinct. The subsequent Danish decisions on duration are independent review findings with their own basis. [136]; [137]; [51].

17 Suspicions and hypotheses requiring further evidence

H01. Deliberate national protection of rights violators as an overall strategy. The material documents mechanisms and specific failures, but not one national agreement or common intent. Necessary evidence: instructions, coordination, warnings received and actual decisions not to pursue accountability.

H02. Serial violations by the same named employee or manager. Necessary evidence: secure person linkage, multiple original events, earlier knowledge, continuing role and new breaches of duty. Anonymised summary entries alone cannot always supply the linkage.

H03. Dismissal or reprisals for lawful professional opposition. Necessary evidence: the specific objection, recipient, employment status, notices, personnel file and actual response. The social workers' study provides a management lead, not a national dismissal count.

H04. Intentional falsification of records or documents in a specific case. Necessary evidence: original, version, amendment log, responsible person, knowledge and significance. The DUBU risk and incorrect attribution of police reports do not on their own prove intentional falsehood in every factual item.

H05. Deliberately cosmetic improvements. Necessary evidence:known lack of effect, a decision to present the problem as solved and specific misleading information. Lack of documented effect already supports criticism of undocumented closure.

H06. Unlawful financial instruction in a specific social case. Necessary evidence: instruction, budget trail, specific binding right, decision and management's knowledge. Financial causation in respondents' assessments must be traced to the originals.

H07. A specific diagnosis, lasting psychological harm or death caused by an authority. Necessary evidence: clinical basis, timeline, specific risk, other documented causes and an expert causal assessment. NMU models and UTH categories cannot establish this on their own.

H08. Abduction, unlawful coercion, abuse of office or gross neglect of duty by a particular person. Necessary evidence: every element of the specific criminal provision, the law in force at the time, conduct, absence of entitlement, culpability and limitation. A documented invalid intervention must still be pursued as such without awaiting a more severe criminal characterisation.

H09. Danish responsibility for specific abuses in Green Desert beyond the available outcomes. Necessary evidence:new relevant primary material concerning control, participation and specific knowledge. The affirmative findings of abuse are retained, while the question of Danish responsibility is assessed under the requirements actually applicable.

H10. A deliberate Danish lie crucial to Samsam’s sentence. Necessary evidence: original sender and wording, knowledge, the complete Spanish legal assessment and causal contribution. The declaratory judgment identifies a central discrepancy but does not replace all these elements.

H11. All private book cases as independently verified breaches of law by authorities. Necessary evidence:the specified original case records, a complete timeline and relevant legal authority. The author’s account of reality and consent must be retained without becoming an automatic certificate of verification.

H12. A specific national total of unique victims, unlawful separation days or unpaid compensation. Necessary evidence: lawful deduplicated person linkage, grounds for decisions, actual intervention, redress and payment. Unknown totals must not be constructed by adding overlapping cases.

H13. Crimes against humanity and individual international responsibility of superiors. Necessary evidence: specific Article 7 acts, a civilian population, a widespread or systematic attack, state or organisational policy, and the relevant actor’s required knowledge and contribution to responsibility. For civilian superiors, effective control, clear information, actual knowledge or conscious disregard, and failure to take necessary reasonable measures must be established separately. The documented administrative failures, accountability mechanisms and Convention violations are relevant lines of inquiry; they do not automatically satisfy all these elements.

18 Missing documents and necessary investigative steps

U01. Children's sector: Original consents and all form versions; urgent and ordinary decisions; approval and competence; current assessments; hearings; the child's statements; action plans; contact decisions; actual relocation, visits and return home; support delivered to the child and parents.

U02. Copenhagen: Borgerrådgiveren's complete 2017 report with the underlying 77 cases; originals for the numbered examples; hospital records in the twins' case; the legal-rights basis in the sisters' cases; dated requests for contact; the municipality's specific response to Borgerrådgiveren's assumption about closure; later correction and loss for each child.

U03. Langeland:all supervisory and Task Force records from the identified chain of knowledge; quality checks of reconsideration; the municipal council’s decision-making basis; the Appeals Board’s basis for rejection and closure; the Ministry’s instruction and documented follow-up; the DUBU log, corrections and any use of incorrect registrations.

U04. National child welfare review: the precise samples and criteria for each year; changed denominators; raw categories; grounds for exceptions; errors, reconsideration and actual outcomes linked to the same anonymised course. Missing public links to individuals must not be replaced by an expected national error rate.

U05. Police: emergency-call recordings, duty logs, reports, use-of-force reports, medical information, original interview records, signature and amendment histories, judgments and the citizen’s actual redress in the identified summary entries.

U06. Police accountability: original complaint, receipt by all bodies, disciplinary recommendation, reasons for delay, actual sanction, continued service, risk assessment and new incidents. Summary and case numbers must be linked to the same employee by the competent scrutiny bodies.

U07. Discontinued criminal cases:the original report to the police, material examined, missing investigative steps, grounds for discontinuance, information to the victim, appeal and reopening; the Minister’s September initiatives traced to actual use and results in new and old cases.

U08. Child psychiatry: referral and actual completion date, diagnostic assessment plan, first contact, registration log, information about rights, offers and actual assistance; the region’s knowledge, corrections and subsequent oversight. Unfinished courses must be shown.

U09. Psychiatric coercion: Precise intervention, start and cessation, every extension decision, continuing necessity, medical supervision, patient adviser, complaint, duration decision, harm, responsibility and payment. Approved initiation and unlawful continuation must be visible within the same case.

U10. Healthcare responsibility: Complaint, compensation decision, professional-authorisation supervision, referral to police, judgment or closure, and actual payment. UTH must be linked to independent evidence where responsibility is investigated on a basis other than reporting.

U11. Social assistance: Application, known need, applicable municipal deadline, information, professional objections, decision, reconsideration, grounds for remittal, back payment and actual provision of personal assistance. Upon retirement and transfer between departments, the continuing need for support must be examined separately.

U12. Duty to provide services:all identified awards lacking delivery, the basis of waiting lists, actual start, the ministerial instruction, municipal responses and results of the announced sample follow-up. A citizen with a favourable decision may still be without assistance.

U13. Managerial governance: budget instructions, decision templates, approval stages, professional warnings, amendments to statements, assessment of orders, personnel cases and actual responses to resistance. Employment role and knowledge on each date must be stated.

U14. Personal data: original statement, lawful basis for processing, collection, disclosure, purpose of use, recipients, correction, search logs and subsequent decisions. Absence of consent must be assessed specifically against any other possible statutory basis.

U15. Stateless persons:person linkage between Commission annexes and court cases; original warnings and versions; decisions and actual citizenship; remedial contacts; personnel-related reasons; requested comparative data and payment.

U16. Tibet:operational orders and emails, all relevant sender and recipient accounts, name variants, searches, archives, submissions to the Commission, court testimony, assessments of responsibility and redress.

U17. Mink: Individual contact and culling, legal authority on each date, the information recipients actually received, corrected message, missing named closure decisions, compensation decisions and payment. The inquiry's scope must be stated in every conclusion.

U18. Defence and intelligence:operational and oversight grounds in Green Desert; original Danish-Spanish communication, SIS history, payment and cooperation evidence in Samsam; complete judgment records and documented subsequent reopening or redress.

U19. Greenland and adoption:the individual historical originals concerning consent, origins and intervention; Danish authorities’ contemporaneous information and actions; present-day access to records, investigation, decisions under the scheme and actual payment.

U20. Courts and compensation:original pleadings, decisions, factual premises, counterevidence, arguments addressed, delays, payer and recipient of costs, payment records and remaining demands. A dismissal must be recorded according to its precise grounds.

U21. Book cases: Consent-based access to the author's original case material or originals supplied by the party; identity verification protected from publication; dates and rules then in force; effect of the decision; person overlap and later status. Case numbers are location identifiers, not personal IDs.

U22. National review of consequences and recurrence:lawful anonymised linkage of errors, citizen, actor, management knowledge, actual cessation, delivery, responsibility and payment. Coverage and missing fields must be stated before national totals are drawn.

U23. International follow-up to judgments and continuing psychiatric interventions: the full text of the Aggerholm judgment and Danish case files; the State’s action plans, scrutiny findings and Committee of Ministers decisions; the original case histories behind the subsequent decisions setting aside durations; links between people, places and instructions; actual cessation, harm and redress. Current international execution status must be documented by the relevant decision.

U24. International-law attribution and chain of responsibility: The body's public function; actual competences of municipality, region, ministry and supervisory body; the relevant private provider's public-authority task or instruction; each warning's sender, recipient and date; the chosen response and actual result. The original act and later omission must be dated separately.

U25. International individual criminal law: original policy, instructions and decisions concerning the alleged Article 7 acts; a delimited population and chain of events; perpetrators’ and superiors’ contemporaneous knowledge and control; the specific nature of the treatment and deprivation of liberty; culpability, harm and causation; precise national investigation and closure records concerning the same persons and acts. This material must be secured without postponing already justified demands for protection and redress.

Original statistical material for the remaining count:the authorities must supply extracts broken down by outcome for the former social appeals boards and employment appeals boards in January–June 2013 and transferred municipal appeal cases in July–December 2013. The extracts must include period allocation, authority, legislation group, upholding, amendment/annulment, remittal for reconsideration, dismissal and an indication of previous second-instance review. Raw outcome counts are also required for the specified gaps in the health and immigration series, and secure pseudonymised linkage between the oversight trail, the incident and actual

remedial action. This is required to count distinct trajectories and cessations, while the figures already checked remain valid.

19 Source and evidence chains for the decisive claims

K01. Twenty years of institutional knowledge in the children's sector. Original practice studies from 2006, 2008, 2009 and 2011 → new samples of cases not appealed in the pilot barometer and annual barometers → Rigsrevisionen's review of out-of-home placements in 2026 → conclusion of repeated, known failure of safeguards. The original studies and more recent samples are different lines of evidence; later references to the old studies belong to the same chain of knowledge. [16]; [17]; [18]; [29]; [26]; [112].

K02. Weakness of the supervisory response. Rigsrevisionen's report 18/2024 → specified population and response outcome → demand to examine choices, follow-up and outcomes for citizens. The supervisory body's own minutes are not independent evidence that the criticised citizen cases were lawful. [106].

K03. Langeland’s continuing errors. Municipal cases and task force reports → dated receipt by Ankestyrelsen → municipal decisions → the supervisory authority’s refusal and closure → the ministry’s demand of 29. May 2026 for a fresh examination. The chain documents a known problem of continuation and oversight. Individual employees’ actions and each individual’s subsequent legal position require case records. [123]; [76].

K04. Copenhagen's aggregate failure of safeguards. Municipal screening → Borgerrådgiveren's verification of case records → the report of 24. May 2017, pp. 6-8, 12-14 and 21-24 → at least one of the deficiencies examined in each of the 77 cases. The screening and the corrected report are stages of the same sample. [84]; [71].

K05. Lack of legal authority or incorrect jurisdiction in contact and removal. The Citizens’ Adviser’s specific record examples 1-16,pp. 66-69 → comparison with consent, legal authority and jurisdiction → demand for cessation and reparation on the documented point. Individual criminal classification requires the additional original record and culpability chain. [84]; [71].

K06. A year without a reviewable contact decision. Dated requests discussed in the Citizens’ Adviser’s example 6→the report’s finding of a late decision→conclusion concerning missing formal access to review. The report’s wording does not replace actual visiting arrangements and precise calendar dates. [84]; [71].

K07. Failure to rescue. Alarm and authority action → disciplinary case summary 2015, no. 21, PDF p. 7 → more than 42 hours and a warning → specific Article 2/3 examination. The summary is a later account; the alarm and rescue file are the next original evidential links. [102].

K08. Accountability lost through time. Disciplinary proceedings → summary 2011, no. 61, PDF pp. 12-13, and 2014, no. 32, PDF p. 9 → expressly stated effect of delay on the response. Responsibility for the delay requires the reporting chain. [100]; [101].

K09. Incorrect report authorship. Interrogation reports and instructions→summary 2006,no. 15→authorship deficiency. False content, judicial use and culpability require separate investigation. [98]; [99].

K10. Unlawful exemption from healthcare responsibility. Administrative practice and disciplinary case → the Ombudsman’s 2010 investigation, [67] → the described twenty-year course of acceptance → conclusion concerning a specific institutional exemption from responsibility. Subsequent cessation requires its own verification.

K11. Assessment failures and misleading registration. Referral data, case-record review and regional registration → Rigsrevisionen’s report 10/2023 and follow-up 2025 → documented delay and registration problem. Multiple referrals per child and unfinished processes are retained as separate units. [107]; [109].

K12. Psychiatric unlawfulness in partial decisions. Grounds of complaint → the patient complaints board’s 2025 tables and separate duration account → precise criticism concerning initiation, procedure and duration. The adverse categories cannot be added to produce unique patients. [51].

K13. Inadequate factual basis in social services. Original practice investigations concerning sickness benefits, young people, flex jobs, pensions and rare disabilities → missing information and safeguards → specific reconsideration under the benefit rule and section 10 of the Legal Safeguards Act. An incorrect award and an incorrect refusal have different chains of consequences. [32]; [30]; [25]; [27]; [34].

K14. Grant without assistance. Grant and actual delivery → the supervisory authority's examination of provision and [36] → the report's distinction between a legally favourable decision and failure to implement it. The duration and consequences for each citizen require grant and delivery data.

K15. Statelessness practice and managerial responsibility. Contemporaneous memoranda and decisions → Statelessness Commission report and responsibility assessments → ministry personnel announcements → judgments of 28. May 2025 and 21. August 2026. Refusal, corrective review, nationality, limitation and payment are separate stages. [116]; [115].

K16. Tibet and retrieval of evidence. Operational orders and emails → the first commission's evidential basis → later document discoveries and Tibet Commission II → errors in the earlier explanation and specific search problems. Reproduction to the Folketing does not count as independent confirmation of a factual statement. [126]; [127].

K17. Acts in the mink case and later responsibility. Letter, action card and knowledge → commission report → delimited inquiries and personnel decisions → conclusion on different action and accountability tracks. An inquiry excluding the action card cannot determine the legality of that action track. [72]; [117]; [83]; [82]; [103]; [70]; [90].

K18. Samsam and authority-based evidence. SIS and Danish-Spanish information → reasons in Spanish judgments → evidence of cooperation in the Danish case → Supreme Court judgment of 2. September 2025. The central discrepancy is identified; the original sender, intent and full causal chain require separate examination. [73]; [96].

K19. Lengthy consideration of compensation. Actual deprivation of liberty → the authority's refusal or reduction of compensation → original judgments and dates → documented corrected outcome and time. Actual payment requires payment records. [129]. [393].

K20. De facto protection from accountability. The specific exemption from record-keeping [67] + the rules on personal financial liability in § 23 of the Liability for Damages Act [58] + specific police, statelessness and commission cases → chapters 5 and 13 → an analytical conclusion concerning particular protective mechanisms. This synthesis is the report's argument; it is not a single statutory immunity or a single statistical measurement.

K21. Management pressure and obedience. Respondent survey [47] → relevant original instructions and personnel measures when supplied → specific decision and loss. Until the last link is available, [47] supports a significant line of inquiry, rather than a proved national risk of dismissal or punishment.

K22. The books' specific stories. Parties' records held by the editorial team or author → a published account in De Retsløse (Forlaget Alternativet, 2025) or Magtmisbrug & Forvaltningskultur (Marie Broberg, 2025) → this report's reproduction with book page and case → required verification against the originals. The chain supports the published story and a specific need for investigation; it is not new independent verification of each record.

K23. Human burden and causation by authorities. The citizen's experience and the articles' theory → a specific timeline of events and health → relevant records and expert assessment of causation → specified loss. The articles by Ole Bakkestrøm and Ronnie Kristensen can define questions and experience, but cannot replace the final evidentiary link.

K24. Failure to protect. Relevant binding right→specific risk facts→the competent body's knowledge or what it ought to have known→realistic relevant protective steps→omission→consequence→State responsibility and a specific remedy. Chapter 6 identifies the tests; no overall error rate replaces them.

K25. Obedience, warnings and protected speech. Official guidance on instructions → original order and professional warning → management's insistence → execution and consequences for the citizen. Ombudsman findings concerning lawful statements → specific management response → individual correction. The two chains examine responsibility for orders and protection of speech respectively; they are not the same case sample. [133]; [134]; [135]; [384]; [385].

K26. Adjudicated Danish violation of Article 3 and subsequent review. Aggerholm judgment entry and official judgment press release → distinction between initiation and continuation → violation of Article 3 → the State's specific follow-up →

later separate duration decisions. The judgment announcement is the Registry's official account, not itself the binding judgment. The evidential status used is stated in chapter 9.9-9.10. [136]; [137]; [51].

K27. Positive protective duties in the children's field. Original placement and concern-report records → the national studies' specific findings on safeguards → Articles 3, 9, 12, 19 and 25 of the Convention on the Rights of the Child and ECHR Articles 3 and 8 according to the nature of the event → omission, significance and specific demand. Z, O'Keeffe and Strand Lobben identify different relevant tests. A percentage does not replace application of the law to the individual facts. [112]; [84]; [390]; [57]; [388]; [56].

K28. State responsibility under international law and redress for the citizen. Relevant binding right at the time of the act → public act or own failure to protect → attribution → specific breaches → cessation, implementation, reparation and relevant steps to prevent recurrence. National limits on liability and organisational allocation do not extinguish the treaty obligation. [61]; [139]; [391]; [138].

K29. Exemption from responsibility and continuing risk. Original serious incident→specific receipt by management or the supervisory authority→investigation and choice of response→continued performance of duties→any new incident→national and relevant human-rights responsibility for both courses. General Comment No. 31,paragraph 18,and Gäfgen, paragraph 125,provide separate international reference points for the serious violations covered. [138]; [55]; [67]; [100].

K30. R2P and international criminal law. UN paragraphs 138-139 and A/63/677 → a defined protection framework → separate identification of any Article 7 acts, context and culpability → national investigation of the same acts → examination of jurisdiction and access. General documentation of systemic failure does not automatically become evidence of international crimes. [140]; [141]; [142].

19.1 Final traceability check

All decisive systemic figures in this report are linked to a specified case sample or a defined registration unit. The same sample, translation and statistical revision have not been added together as new independent populations. Source conflicts, unfinished courses and unknown payment are retained as specific local information.

The traceability check requires that the reader can move from an actual claim to the named public original, the relevant passage and its method. The references to the law and to the judgment identify the provision or the premise. The published book reports are identified by title, author, year, case and page. The report does not certify that unpublished back-up documents are independently controlled; this difference is apparent from the reports in question.

For the Holstebro and book cases, the original case records must be produced to substantiate a specific allegation of personal responsibility. The published account and information reproduced in this report retain their stated evidential status independently. This does not alter the independently documented systemic findings; it identifies the precise investigation the responsible authority or an independent scrutiny body must conduct.

The report can thus be used as a single document and letter of claim. The actual submission in an individual case must be accompanied by the originals, party information, claim and legal basis of the case in question. The strongest case is the one in which every required result can be followed back to a particular act, duty and chain of proof.

20 Appendix A – location index for Magtmisbrug & Forvaltningskultur

The case overview refers to Marie Broberg's published book [1]. Page numbers are those of the book. The excerpts are published accounts; the independent evidential status of the underlying case files and the requirement to check the originals are addressed in Chapters 12 and 18.

All excerpts below are Marie Broberg’s published case descriptions from Magtmisbrug & Forvaltningskultur (2025). The case and book page identify the relevant part of the work. The excerpts serve to locate material and guide investigation; they do not constitute new independent verification of actions by named authorities or individuals. The author’s description of sources appears on p. 3. The complete underlying records must be examined for an individual allegation of responsibility. An introductory description must not be used to assert a later outcome that the book does not document.

Necessary checks for each case: dated original application and decision; quoted professional document; specific replies and changes of the Authority; applicable rule for the particular benefit; actual help and waiting period; liability and subsequent redress. More people or the re-use of a name must not become a count of new victims without a connection. Number 139 is twice in the book.

Case 1 · p. 17

Book excerpt:“Malthe is 7 years old and diagnosed with infantile autism and sensory integration difficulties. He has difficulty with transitions, personal hygiene and social relationships.”

Case 2 · p. 32

Book excerpt: "Signe is 9 years old and has a significant reduction in function, with a need for special pedagogical support at home. There is no doubt about the level of function - this is evident from both medical, pedagogical and psychological assessments. "

Case 3 · p. 54

Book excerpt: “A family seeks help because their 6-year-old son, Noah, has significant language difficulties and is not thriving in kindergarten. The parents contact the municipality seeking speech and language therapy support.”

Case 4 · p. 55

Book excerpt: “Mads is the father of Emma, 9,who has ADHD. He attends every meeting at the municipality together with Emma’s mother.”

Case 5 · p. 55

Book excerpt:“Lene is the mother of Sofie, aged 4,who was born with hearing loss. The municipality sends an occupational therapist, a speech therapist and a psychologist to assess the need for support in daycare.”

Case 6 · p. 58

Book excerpt: “Maria and Anders approach the municipality because their daughter Freja, aged 7, shows signs of anxiety and struggles to attend school. The municipality offers a psychological assessment.”

Case 7 · p. 59

Book excerpt:“Peter and Camilla have a son, Jonas, aged 10,who has autism and major difficulties at school. They seek support for respite care.”

Case 8 · p. 60

Book excerpt: “Sanne and Henrik have a daughter, Clara, 5,who has sensory integration difficulties. She is referred for an occupational therapy assessment.”

Case 9 · p. 61

Book excerpt: “Jonas, aged 4, struggles to pronounce several sounds. His parents seek help through the nursery, which contacts a speech therapist.”

Case 10 · p. 62

Book excerpt:“Ahmed and Aisha have a daughter, Leila, aged 8,who has epilepsy and major learning difficulties. They have had contact with a psychologist, speech therapist, occupational therapist and social worker.”

Case 11 · p. 65

Book excerpt:“Line and Thomas seek help for their son, Malte, aged 6,who has major difficulties with restlessness and concentration. They describe his difficulty sleeping, his strong reactions to sounds, and their use of a ball-filled vest and weighted blanket at home to help him.”

Case 12 · p. 66

Book excerpt: “Sofie is 9 and has epilepsy. An occupational therapist is to assess her to establish her support needs at school.”

Case 13 · p. 67

Book excerpt: "Helene has a son, Viktor of 7 years old, who has great sensory challenges. He does not like touch, reacts violently to sounds and has difficulty settling in kindergarten. "

Case 14 · p. 67

Book excerpt:“Rasmus and Julie are the parents of Alma, aged 11,who suffers from anxiety and cannot attend school. They meet a municipal psychologist to obtain help.”

Case 15 · p. 68

Book excerpt: “Mette is a single mother of two children. Her youngest, Lukas, age 5, has developmental difficulties and major language difficulties.”

Case 16 · p. 71

Book excerpt: “A licensed psychologist assesses 9-year-old Karoline at school. She is described as ‘acting out’ and ‘lacking social understanding’.”

Case 17 · p. 72

Book excerpt: “Jesper is the father of a boy aged 12 with ADHD. He finds that the boy is suffering severely at school and documents this with diaries, videos and teachers' statements.”

Case 18 · p. 73

Book excerpt: “Anna seeks support for her son, Elias, 10,who faces major difficulties at school. The municipality sends a licensed psychologist who observes Elias during a single mathematics lesson.”

Case 19 · p. 74

Book excerpt: “A family complains about a psychologist's report describing their daughter as ‘acting out’ on the basis of a single test. The complaint is sent to the municipality, but handled by the same department that commissioned the report.”

Case 20 · p. 74

Book excerpt: “An occupational therapist tests a boy aged 6 and concludes that he has ‘reduced endurance and willingness to cooperate.’ The parents object: ‘He had epileptic seizures the previous evening and was exhausted.’ The municipality maintains the report and refuses support. The point: A superficial observation becomes truth because it is supported by a professional title, while the child's reality is overlooked.”

Case 21 · p. 74

Book excerpt: “A school sends letters of concern about a girl who often breaks down in class. The municipality obtains a psychological report concluding: ”The child appears calm and well-adjusted.” When the teachers protest, they receive the reply: ”We rely on the authorised report.” The point: Even professionals in the child’s daily life lose influence when an authorised assessment is available.”

Case 22 · p. 77

Book excerpt: “Sarah is the mother of a boy aged 7 with autism. For months she has tried to get the school and municipality to provide the support he needs: a specialist educator during lessons and a structure that can help him thrive.”

Case 23 · p. 78

Book excerpt:“A family is fighting for support for their daughter, Sofie, aged 8,who suffers from anxiety. The school makes repeated notifications that she cannot attend school, and her parents support the descriptions.”

Case 24 · p. 79

Book excerpt: "Mikkel is 10 years old and has ADHD. His parents experience that he thrives well at home, but that he has difficulty in school where there is a lack of support. "

Case 25 · p. 83

Book excerpt: "Katrine is the mother of a 6-year-old boy with epilepsy. She meets a school psychologist to discuss his absence due to many seizures. "

Case 26 · p. 84

Book excerpt: “Jonas, age 9, has ADHD. His parents apply for school support because he often breaks down in class and cannot keep up.”

Case 27 · p. 85

Book excerpt: “Martin is the father of a girl aged 11 with autism. He seeks support for respite care because the family is under strain.”

Case 28 · p. 86

Book excerpt: “Laura is 7 and has epilepsy combined with cognitive difficulties. Her parents apply for a full-time educator at school because she needs supervision during seizures and help with learning.”

Case 29 · p. 89

Book excerpt: “At a meeting with the municipality, Maria, a mother of two, becomes frustrated. She says: ”I cannot go on unless I get help.” The subsequent case note says: ”The mother appears to be giving up on fulfilling the parental role.” The sentence, intended as a cry for help, is read as a sign of failure.”

Case 30 · p. 90

Book excerpt: “Emil, 7,was assessed by a psychologist who concluded: “The child appears anxious and inhibited in social relationships. The parents seem overinvolved.” The parents were shocked.”

Case 31 · p. 91

Book excerpt: “Camilla seeks help for her son, who has severe difficulties with anxiety. She hopes for support at school and respite care at home.”

Case 32 · p. 92

Book excerpt: “At a meeting with the municipality, a social worker notes: ‘The father appears dominant in the conversation.’ This is a loose observation written in a case note. Months later the sentence appears in a psychologist's report: ‘It is confirmed that the father can seem dominant in cooperation.’ Later an action plan states: ‘To support the family, the father must work on toning down his dominant manner.’ Finally, the wording is used as grounds in a decision refusing respite care: ‘Because of difficulties in cooperation, it is assessed that the family cannot benefit from further support.’ The father experiences how a single sentence, written on the basis of a subjective […]”

Case 33 · p. 93

Book excerpt: “Peter was in his 30’s when he first came into contact with the municipality in connection with his son, who had learning difficulties. In a report, a social worker wrote: ”The father appears to have limited resources.” Ten years later, when Peter applies for support for his youngest daughter, who has completely different difficulties, the old wording appears in the case.”

Case 34 · p. 95

Book excerpt: “The family of Ida, 8,who has autism, experiences a year in which the municipality summons them to no fewer than twelve meetings. Social workers, the school, PPR and a psychologist attend the meetings.”

Case 35 · p. 96

Book excerpt: "At a status meeting about her son Lene tries to explain what everyday life looks like at home: the son wakes up several times at night, he gets anxiety attacks and the family is exhausted. After a few minutes, she is interrupted by the head of the meeting: "We need to focus on the agenda." Later in the meeting, the school psychologist gets the floor. "

Case 36 · p. 97

Book excerpt: "Thomas is the father of a girl with autism. He's been fighting for years to get the necessary support at school. "

Case 37 · p. 98

Book excerpt:“At a follow-up meeting, Maja, the mother of a boy with ADHD, says that he is doing better at home but still struggling at school. She repeatedly stresses that he needs support during lessons.”

Case 38 · p. 99

Book excerpt: "Signe is 9 years old and has anxiety. Her parents are looking for help with support at school because she can't keep up. "

Case 39 · p. 101

Book excerpt: “Malthe, age 10, has epilepsy with daily seizures. His paediatrician at the university hospital recommends close adult support at school and records this in a detailed statement.”

Case 40 · p. 101

Book excerpt: “The family of Sofie, 12,experiences her severe distress at school. The municipality refuses to conduct a psychological assessment, so the parents choose to pay a private psychologist themselves.”

Case 41 · p. 102

Book excerpt: "A municipality hires a well-known psychologist to teach their employees in children's emotional development. The psychologist is referred to in the municipality's newsletter as "one of the country's leading experts." "

Case 42 · p. 103

Book excerpt: “The family of Alma, aged 9, has fought for support for several years. They have statements from a paediatrician, the school and a private psychologist.”

Case 43 · p. 106

Book excerpt: “A boy aged 7 with epilepsy had a clear hospital recommendation: close adult support during every lesson. The municipality overlooked the document in its initial decision and refused the application.”

Case 44 · p. 106

Book excerpt: “For a year, a family had not received the respite care specified in the action plan. When the parents asked how this could happen, the municipality replied in a new note: ”The intervention has been implemented to the extent possible given resources.” The fact was that the family had received nothing at all.”

Case 45 · p. 107

Book excerpt: “A family appeals against a refusal of a special school for their daughter with severe autism. The case is sent to Ankestyrelsen, where it remains in the queue for over a year.”

Case 46 · p. 107

Book excerpt: “A father complains that the municipality has refused support even though his son has a clear specialist medical statement. The answer he receives is: ”The complaint cannot be considered because it was not submitted within the applicable time limit.” The fact that the decision rested on a manifest disregard of medical evidence is never investigated.”

Case 47 · p. 108

Book excerpt: “A mother of a boy with autism repeatedly calls the municipality because her son can no longer attend school. She demands an answer: ”Why is nothing happening?” The subsequent file note states: “The mother appears very insistent and seems to have difficulty cooperating.” Her criticism of the system’s inaction is not seen as an expression of care - but as a sign that she herself is part of the problem.”

Case 48 · p. 108

Book excerpt: “A father complains that the municipality has refused respite care even though the family is close to breaking down. He writes a long email describing the child’s situation in detail.”

Case 49 · p. 109

Book excerpt:“Emma, aged 8,has anxiety and cannot attend school. Her parents apply for support in January.”

Case 50 · p. 109

Book excerpt: "A boy with autism and epilepsy has repeated epileptic seizures in school. The hospital recommends close support. "

Case 51 · p. 110

Book excerpt: “A municipality issues a press release about an ”enhanced focus on children with special needs”. The image shows children in colourful rooms under the heading: ”We create conditions for well-being.” Meanwhile, a local family has struggled for more than two years to obtain support for their son with autism.”

Case 52 · p. 110

Book excerpt: "A municipality aims to draw up all action plans within four weeks. The figure becomes an internal success criterion, to which all case handlers have to live up to. "

Case 53 · p. 114

Book excerpt:“Maja is 7 years old and struggles at school. She breaks down several times daily, cannot follow the lessons and develops severe anxiety.”

Case 54 · p. 115

Book excerpt: “Caroline is 11 and has an ADHD diagnosis. Her school applies for extra support because she loses engagement in lessons daily and experiences intense emotional outbursts.”

Case 55 · p. 116

Book excerpt: "The family of Sofus aged 9 applies for support at home because they are exhausted after several years of sleepless nights and school breakdown. In the case manager's assessment it says: "Parents appear resourceful and well-formulated." The consequence is that the application is rejected: Resource strong parents are not considered to need help - even if in practice they are breaking down. "

Case 56 · p. 116

Book excerpt: "A mother of a girl with epilepsy writes detailed diaries of the seizures and insists that the school and the municipality take them seriously. In a note, she is described as "overinvolved and persistent." "

Case 57 · p. 117

Book excerpt: “Lukas was assessed and diagnosed with autism at the age of 7. The psychological report stated: “The child appears socially inhibited and unable to participate in group settings.” Three years later, Lukas had a new teacher and a new class and was thriving significantly more.”

Case 58 · p. 117

Book excerpt: “Maria has a son with ADHD and anxiety. In an early report she was described as ”overinvolved in the child’s difficulties”.”

Case 59 · p. 120

Book excerpt: “Noah, age 6, has epilepsy with frequent seizures. His paediatrician writes a detailed statement about the need for a support person at school.”

Case 60 · p. 121

Book excerpt: “Anna and Emil, both 9,have the same diagnosis: childhood autism. They struggle to be in class, quickly become overstimulated and need support persons at school.”

Case 61 · p. 122

Book excerpt: “Frederik, 12,has severe epilepsy and a developmental disorder. The family applies for specialised respite care with staff experienced in medication management and epilepsy alarms.”

Case 62 · p. 123

Book excerpt: “Jonas, aged 8, has autism and extensive absence from school. The school and parents seek support.”

Case 63 · p. 124

Book excerpt: “Laura, age 10, has severe epilepsy and attends a special school. The school requests additional support because her seizures have become more frequent and require close supervision.”

Case 64 · p. 127

Book excerpt: “A family seeks respite care for their son with severe ADHD. They request an arrangement of 10 hours per month, corresponding to an expenditure of approximately 25.000 kr.”

Case 65 · p. 128

Book excerpt: "A family with a girl with autism experiences that she cannot be in school without support. Instead of granting a support person, the municipality calls a number of interdisciplinary meetings: PPR-psychologist, social worker, school manager, teacher and consultant. "

Case 66 · p. 129

Book excerpt: "A 13-year-old boy needs a special pedagogical effort at school. Parents apply for aid amounting to DKr 55.000 per year. "

Case 67 · p. 130

Book excerpt: “Oliver, age 10, has autism and severe anxiety. The school and family recommend a special class.”

Case 68 · p. 131

Book excerpt: “A family requests support costing 900.000 kr. annually in the form of a special school for their son with autism. The municipality refuses and instead offers inclusion with a few hours of support.”

Case 69 · p. 134

Book excerpt: “The family of Ida, age 7, applies for respite-care support. They produce statements from both school and paediatrician, all pointing to an extensive need.”

Case 70 · p. 135

Book excerpt: “The family of Elias, 12,presents a statement from child psychiatry in which the doctor clearly recommends special education and close support. The statement describes the risk of serious failure to thrive unless the intervention is provided promptly.”

Case 71 · p. 136

Book excerpt: “Sara, aged 9, has severe epilepsy. Her parents apply for coverage of additional expenditure on medication and transport.”

Case 72 · p. 137

Book excerpt: “A family appeals a refusal of support for their son with autism. After waiting eight months, they receive a reply running to 12 pages.”

Case 73 · p. 138

Book excerpt: “A mother applies for support under section 52 of the Social Services Act for her daughter, who has extensive anxiety. The school supports the application, and the doctor clearly describes the need.”

Case 74 · p. 140

Book excerpt: "A family in a medium-sized municipality appears in the press because their daughter, with autism, has not been taught for over a year. Teachers, doctors and experts support the family. "

Case 75 · p. 141

Book excerpt: “In a municipality, it emerges that several children with disabilities have gone for years without the support they were granted. Local media uncover documentation showing systematic failures.”

Case 76 · p. 142

Book excerpt: “In a municipality in Jutland, parents criticise children with special needs systematically being refused support. The local press contacts the mayor for comment.”

Case 77 · p. 143

Book excerpt:“A councillor in a larger municipality raises in the council chamber the question of why several children with disabilities have no education. The question rests on specific approaches from families and documentation in the press.”

Case 78 · p. 144

Book excerpt: "In a municipality, a local parent group collects documentation from over a hundred families who all experience that their children do not receive the support they have been granted. The group sends the material to the city council and requires an investigation. "

Case 79 · p. 145

Book excerpt: “After a local TV station revealed that several children with disabilities were not receiving the support awarded, the mayor issued a press release. It contained not a single admission, instead highlighting the municipality’s “major inclusion effort” and “positive development in children’s communities”.”

Case 80 · p. 145

Book excerpt: "A family with a son in special class contacts a councillor directly after several unsuccessful attempts to get support. They hope that their history can raise a political discussion about the municipality's priorities. "

Case 81 · p. 146

Book excerpt:“In a municipality, the opposition presents a proposal to investigate case processing concerning children with disabilities. Several members of the majority privately agree that something is wrong—but no one votes in favour.”

Case 82 · p. 148

Book excerpt: “A local newspaper received substantial advertising revenue from the municipality every year in connection with branding campaigns. When the town’s parent group began raising criticism of the disability field, the newspaper published a single article – without following up, even though the stories were piling up.”

Case 83 · p. 149

Book excerpt:“The mother of a boy with severe autism speaks out in the local newspaper. She says that her son has been without schooling for eight months because the municipality refuses to grant special provision.”

Case 84 · p. 150

Book excerpt: “A national newspaper publishes an article about a family whose son with epilepsy has not received support at school despite repeated medical certificates. The story is described in detail, and readers are shaken.”

Case 85 · p. 151

Book excerpt:“After a number of parents in a municipality speak out in the media and criticise long case-processing times, the local press contacts the administration for answers. The journalist asks to interview the area manager.”

Case 86 · p. 151

Book excerpt:“A regional TV station produced a feature about a family whose son with ADHD had been at home without education for more than a year. The feature began with the parents’ account, but ended with the mayor’s comment:‘We cannot comment on individual cases, but I can assure you that we always prioritise the child’s best interests and work under the legislation in force.’ The feature was edited so that the mayor’s words provided the concluding frame.”

Case 87 · p. 152

Book excerpt: "In a municipality several children were without education for months. Local media brought short stories, but all were quickly rejected as "single cases." "

Case 88 · p. 153

Book excerpt: “A couple in a municipality spoke publicly in a national newspaper because their daughter with cerebral palsy was not receiving aids she had been granted. The newspaper ran their story – but then gave the floor to the municipality’s director, who explained that “cases are always assessed thoroughly, and the law is followed.” No questions were asked about why several other families in the same municipality had experienced exactly the same thing.”

Case 89 · p. 154

Book excerpt: “In one part of the country, local media had uncritically reproduced the municipality’s responses for years. But after repeated approaches from parents, an editorial team changed strategy: they began collecting cases, analysing patterns and confronting the mayor with the fact that ten children were without schooling - not just one.”

Case 90 · p. 157

Book excerpt: “A mother of a child with ADHD felt completely alone in her struggle against the municipality. She had spent months seeking support, but was met with refusals and suspicion.”

Case 91 · p. 157

Book excerpt: “A group of parents created a shared folder online where they put templates for access to records, examples of decisions and guides to the complaint system. When a new family joined the group and said they did not know how to obtain access to their case, they could download a ready-made guide, complete it and send it that same day.”

Case 92 · p. 158

Book excerpt: "A mother had to meet with the municipality about support for her daughter with autism. In the past she had left the meetings crying because she felt pressed and misunderstood. "

Case 93 · p. 159

Book excerpt: “A father shared a post about his son, who had been without schooling for more than a year. He attached decisions and appeal letters and explained precisely how the municipality dragged the case out.”

Case 94 · p. 160

Book excerpt: “Within a few months, a parents’ group grew from 50 to 3.000 members. The group became a lifeline for many, but also a burden for those administering it.”

Case 95 · p. 161

Book excerpt: "In the same municipality, two families sought support for children with autism. One family was part of a large parent group on social media and was helped to formulate the application, make access to documents and complain when the refusal came. "

Case 96 · p. 161

Book excerpt: “A nationwide TV station produced a feature about a Facebook group where thousands of parents of children with disabilities share experiences. The journalist noted that members had created their own guides to access to records and complaints because the municipality did not guide them.”

Case 97 · p. 172

Book excerpt: “A father sought support for his 14-year-old son with severe anxiety. The boy had not attended school for eight months, had diagnoses from child psychiatry, and both doctor and psychologist described a need for a special educational intervention.”

Case 98 · p. 173

Book excerpt:“A mother appealed the municipality’s refusal of lost-earnings compensation for her son with epilepsy. She argued by reference to the statutory provisions on necessary caring tasks.”

Case 99 · p. 174

Book excerpt: “A boy aged 9 with muscular dystrophy was refused a specialised wheelchair. The family appealed to the Appeals Board with support from a doctor and a specialist hospital.”

Case 100 · p. 175

Book excerpt: “A mother complained that the municipality had refused support for her son's school transport. When she received Ankestyrelsen's decision, she noticed that its wording was almost word for word the same as in the municipality's original refusal.”

Case 101 · p. 175

Book excerpt: “A family who had complained about the lack of schooling for their child was addressed by the mayor at an open council meeting. The mayor rejected the criticism with the words: ‘The family can complain to Ankestyrelsen if they believe errors have been made.’ But the family had already complained.”

Case 102 · p. 176

Book excerpt: “A family complained to the Ombudsman after three years of struggling to obtain support for their son's schooling. After 11 months of processing, they received the reply: The Ombudsman expressed ‘concern about case-processing time’ and ‘recommended that the municipality ensure future compliance with the statutory framework.’ The municipality noted the remark, but did nothing to change the boy's situation.”

Case 103 · p. 177

Book excerpt: “A girl with diabetes was refused support for assistance at school. The family appealed and only obtained a favourable decision from Ankestyrelsen after a year and a half.”

Case 104 · p. 180

Book excerpt: “A family in Aalborg was refused home training for their son with disabilities. At the meeting the municipality's lawyer said: ‘The Social Services Act does not permit home training in the form you are applying for.’ The family went home devastated – they thought they had misunderstood the law.”

Case 105 · p. 181

Book excerpt: “A mother in Aalborg complained about the municipality's refusal of support for her son's assistance with leisure activities. She had prepared thoroughly, read the Social Services Act and brought references to its sections.”

Case 106 · p. 182

Book excerpt: “During a meeting, a father asked the municipal legal adviser how the Child’s Act protects his daughter’s right to a stable placement. The adviser replied: “I cannot go into that, but I can say that the municipality has discretion to make the decision.” The answer was not technically incorrect, but revealed a lack of insight into the specific legislation.”

Case 107 · p. 183

Book excerpt: “A family in Hillerød was told by the municipality’s legal officer that they “could not have additional expenses for their son’s insulin pump covered, because medical equipment was not covered by the Social Services Act.” The parents took the legal officer’s word at face value. Only a year later – with help from a private social worker – did they discover that insulin pumps are indeed covered by the rules on additional expenses when necessary for the child’s illness.”

Case 108 · p. 184

Book excerpt:“A father from Odense was called to a meeting about support for his daughter. When he entered the room, five people from the municipality were sitting there:a caseworker, psychologist, consultant, manager and lawyer.”

Case 109 · p. 185

Book excerpt:“A single mother of a boy with ADHD had fought for support for years. She had received refusal after refusal, all with reasons given by the municipality’s lawyer.”

Case 110 · p. 186

Book excerpt: "A family in Esbjerg had a children's case opened, where the municipality believed that the 7-year-old boy should be placed outside the home. The family asked for a lawyer, but was told that they had to pay for themselves. "

Case 111 · p. 188

Book excerpt: “The mother of a boy with multiple diagnoses had fought for support for years. She juggled work, meetings, refusals and sleepless nights.”

Case 112 · p. 189

Book excerpt:“In a North Jutland municipality, a caseworker broke down with stress after a period of heavy workload. The municipality responded quickly:she was offered sessions with a psychologist, sick leave on full pay and close follow-up from HR.”

Case 113 · p. 190

Book excerpt: “The father of a girl with severe epilepsy had struggled for months to obtain an epilepsy alarm and respite care. He worked full-time while also keeping night watch at home because his daughter could have a seizure at any time.”

Case 114 · p. 193

Book excerpt: “Emilie, age 9 Emilie is asked by a social worker whether she likes school. She replies: ‘Sometimes, but I get upset when the teacher shouts.’ The case note states: ‘The child indicates that she generally thrives at school, but has a tendency to focus on negative episodes.’ The child's words are precise, specific and understandable: She gets upset when an adult shouts.”

Case 115 · p. 194

Book excerpt: “Malik, 12 years old Malik is interviewed by a psychologist in connection with a child welfare assessment. He says: “I am afraid that I will be taken away from my mother.” A raw, honest sentence.”

Case 116 · p. 195

Book excerpt: “Noah, 7 years old Noah is observed at nursery as part of a child welfare assessment. He plays alone in the sandpit.”

Case 117 · p. 197

Book excerpt: "Line, 14 years old Line has lived her entire life with municipal cases of support for her disability. When she gets access to documents at the age of 14, she reads for the first time how she has been described over the years. "

Case 118 · p. 198

Book excerpt: "Sara, 11 years old Sara lives in a family where her mother is constantly fighting with the municipality for help for Sara's epilepsy. Sara sees how the mother spends nights writing mails and days sitting in meetings where she is criticised. "

Case 119 · p. 199

Book excerpt: “The concern report about Mads Mads, 8 years old, lives with his parents, who apply for respite care. A teacher makes a concern report stating: “The child is clearly not thriving, which supports the need for a parenting capacity assessment.” Here, the child’s failure to thrive is used not to initiate support for the child – but as an argument for checking the parents.”

Case 120 · p. 200

Book excerpts: "In a municipality, a new model is tested, allowing children to write letters directly to decision-makers - without passing through the social worker's filter. Emma, 10 years old, writes, "I want to stay at my school because I feel safe there."

Case 121 · p. 204

Book excerpt: "Jonas, 9 years old Jonas is a boy with autism who needs a support person at school. The municipality rejects the application with the justification: "The school itself must organise the teaching within the existing framework." The result is that Jonas can only be in the class for short periods. "

Case 122 · p. 205

Book excerpt:“Amalie, 11 years old Amalie finds calm when she rides. She says herself:‘When I am on the horse, I forget everything that is difficult.’ Her parents seek support for riding therapy because they see that it is the only place where Amalie calms down.”

Case 123 · p. 206

Book excerpt: “Daniel, aged 13 Daniel had a best friend with whom he used to play football after school. But after a year of repeated meetings, assessments and refusals, the friend begins to withdraw.”

Case 124 · p. 207

Book excerpt: “Sofie, 15 years old Sofie has had municipal cases surrounding her since she was little. One day she gains access to her case files together with her mother.”

Case 125 · p. 208

Book excerpt: "Anna, 10 years old Anna lives with her mother and little brother. The municipality decides to make unannounced home visits "to get a true picture of everyday life." "

Case 126 · p. 209

Book excerpt: “Marcus, 16 years old Marcus has lived with municipal cases since he was little. When a support person asks him what he wants most, he replies: “I just want a normal life.”

Case 127 · p. 212

Book excerpt: “Maria, mother of two Maria seeks help because her son has complex epileptic seizures. She asks for everyday support so she can care for both him and his younger sister.”

Case 128 · p. 213

Book excerpt: “Ida, age 8 Ida has an older brother with an extensive developmental disorder. He has a regular social worker, psychologist and educator assigned to him.”

Case 129 · p. 214

Book excerpt: "Lene and Thomas are the parents of a boy with severe seizures of epilepsy. For years they have been seeking help from the municipality, but have been repeatedly refused. "

Case 130 · p. 216

Book excerpt: “Jonas, age 7, loves camping with his parents and sister. The family usually goes every summer, but one year they have to stay home because the municipality announces unannounced home visits.”

Case 131 · p. 217

Book excerpt: “Oliver, 12 years old Oliver lives in a family where his mother is constantly in conflict with the municipality over support. One day a caseworker says to him: “You can tell me if you are sad.” Oliver replies: “No, because then you say Mum does not look after me well enough.” He has understood the logic: his words can be used as a weapon – not against himself, but against his mother.”

Case 132 · p. 218

Book excerpt: “Signe, age 9 Signe is playing on the floor when there is a knock at the door. A caseworker enters without warning.”

Case 133 · p. 223

Book excerpt: “Aisha, age 3 – two scenarios, two bills Early signs in nursery: Slow to join group activities, covers her ears during the tidy-up song, conflicts in the cloakroom. Standard trajectory (expensive): ‘Wait and see’ → changing temporary staff → PPR referral (waiting time) → no change in the environment → preschool without structure → early primary years with initial days of absence → middle primary years: involuntary school absence → psychiatric care.”

Case 134 · p. 226

Book excerpt: “Mikkel, aged 11 • First signs: In grade 1, Mikkel regularly complains of stomach aches. He is allowed to stay home for 1–2 days a month.”

Case 135 · p. 228

Book excerpt: “Nadia, 14 years old • Background: Already in kindergarten, Nadia showed clear signs of sensory overload. She covered her ears, cried during group time and refused shared meals. • School: In the early school years, she developed severe anxiety about school breaks.”

Case 136 · p. 230

Book excerpt: “Jonas, aged 19 • Background: Jonas already had difficulty with transitions in daycare, but the family received no support. • School: Extensive absence from grade 5. The municipality concluded: “The parents are not consistent enough.” • Youth: No grade 9 examination, no access to education.”

Case 137 · p. 232

Book excerpt: “The council meeting In a medium-sized municipality, the council discusses allocating 10 million to stronger daycare intervention. An official presents a calculation showing that the investment will significantly reduce the need for special-school places in 8–10 years.”

Case 138 · p. 234

Book excerpt:“A municipality refuses support for a boy with early signs of anxiety. The reason is:‘The intervention is not considered necessary.’ The municipality saves 80.000 kr. by omitting a support person.”

Case 139 · p. 236

Book excerpt: “Camilla is fighting to obtain support for her son with autism. At a meeting, the caseworker says: “I can see you are frustrated.”

Case 139 · p. 238

Book excerpt: "Henrik and Line are told that the municipality will make a" follow-up visit. " They're expecting a conversation. "

Case 140 · p. 239

Book excerpt: “Mette, a social worker Mette worked for many years with families in severe distress. When she started, she sometimes cried after meetings because the stories made such a strong impression.”

Case 141 · p. 240

Book excerpt:“Jakob, municipal lawyer Jakob tells a mother that her daughter cannot receive support before there is a psychiatric diagnosis. The mother protests:‘But the law says support must be given on the basis of the child’s needs, not a diagnosis?’ Jakob replies:‘That is the municipality’s practice.’

Case 142 · p. 241

Book excerpt: "Sofie, 10 years old Sofie has epilepsy and massive school absenteeism. Parents explain that seizures and medications make school day unmanageable. "

Case 143 · p. 243

Book excerpt: “Louise, a psychologist in PPR Louise says that as a new employee she wrote in a statement: “The child clearly expresses anxiety and is not thriving.” Her manager edited the document and wrote: “The child appears challenged in social situations.” Louise initially protested, but was told: “We do not use words resembling diagnoses. They can trigger expensive interventions.” After a few months, she began writing that way herself.”

Case 144 · p. 248

Book excerpt:“The Kristensen family seeks respite care for their daughter, Sofie, aged 9,who has epilepsy and severe sensory disturbances. Her mother has documented sleepless nights, seizure records, statements from the paediatrician and a detailed calendar of how many times Sofie is awake each night.”

Case 145 · p. 249

Book excerpt:“Child:‘A’ (8 years). Diagnoses:epilepsy, autistic traits, sensory difficulties.”

Case 146 · p. 255

Book excerpt: "Child:" Emma "(10 years). Diagnoses: ADHD and anxiety. "

Case 147 · p. 258

Book excerpt: "Child:" Noah "(7 years). Diagnoses: infantile autism, language difficulties. "

Case 148 · p. 261

Book excerpt: “Child: Freja (age 6). Diagnoses: cerebral palsy, need for a wheelchair and intensive physiotherapy.”

Case 149 · p. 263

Book excerpt:“Lucas is 9 years old and diagnosed with severe ADHD and Tourette syndrome. He needs close adult support, structure and respite care at home.”

The financial amounts, diagnoses and interpretations of the law of the book are the information of the book. They're not verified by private originals here. Case 149's incomplete § xxreference and the other concrete legal claims must be replaced by controlled rules in an individual case.

21 Annex B - Locator index for De Retsløse

Chapters and page numbers refer to De Retsløse [2]. The direct links to the individual parts of the book are collected in the bibliography.

The register ensures that the personal chapters form specific subjects of investigation. Each link opens the relevant part of Forlaget Alternativet's publicly available edition of De Retsløse (2025). The book's accounts are the first link in the source chain, to be traced to party-held case records and actual subsequent status.

Helle Øbo: [2]. Verification: known need, application or intervention, original decision, appeal, actual assistance or cessation, timeline, loss and responsibility.

Elsebet: [2]. Verification: known need, application or intervention, original decision, appeal, actual assistance or cessation, timeline, loss and responsibility.

Mohammad: [2]. Verification: known need, application or intervention, original decision, appeal, actual assistance or cessation, timeline, loss and responsibility.

Sofie: [2]. Verification: known need, application or intervention, original decision, appeal, actual assistance or cessation, timeline, loss and responsibility.

Jane: [2]. Review: known need, application or intervention, original decision, appeal, actual assistance or cessation, chronology, loss and responsibility.

Omsorgssøsteren: [2]. Verification: known need, application or intervention, original decision, appeal, actual assistance or cessation, timeline, loss and responsibility.

Hanna: [2]. Review: known need, application or intervention, original decision, appeal, actual assistance or cessation, chronology, loss and responsibility.

Karsten: [2]. Verification: known need, application or intervention, original decision, appeal, actual assistance or cessation, timeline, loss and responsibility.

Ira: [2]. Verification: known need, application or intervention, original decision, appeal, actual assistance or cessation, timeline, loss and responsibility.

Vera: [2]. Verification: known need, application or intervention, original decision, appeal, actual assistance or cessation, timeline, loss and responsibility.

Søren: [2]. Review: known need, application or intervention, original decision, appeal, actual assistance or cessation, chronology, loss and responsibility.

Yasmin: [2]. Verification: known need, application or intervention, original decision, appeal, actual assistance or cessation, timeline, loss and responsibility.

Maya: [2]. Review: known need, application or intervention, original decision, appeal, actual assistance or cessation, chronology, loss and responsibility.

Christina: [2]. Review: known need, application or intervention, original decision, appeal, actual assistance or cessation, chronology, loss and responsibility.

The specific information in Elsebet's and Mohammad's cases is examined in chapter 10.3. Christina's identified medical counter-evidence and local legal boundaries are examined in chapter 12.12. The book's introductory and legal-policy contributions are used to formulate questions concerning accessible review; they do not prove the judicial arrangements of every country or the culpability of a particular Danish authority.

22 Annex C - Verification form for each allegation of responsibility

Claim: The precise conclusion, authority, actor, period and desired legal consequence.

Authority's statement: Wording, document, author, date, recipient and the asserted factual source.

Original evidence: Contemporaneous original, version history, authenticity, specific locator and evidential status.

Deficiency: The factual contradiction, omission, failure to investigate or untenable inference.

Rule: The provision in force at the relevant time and all its relevant conditions of application, conduct and culpability.

Action or omission: Who did or omitted what, under which powers and at what time.

Knowledge: Actual receipt, documented understanding or the specifically relevant knowledge that ought to have been held.

Legal departure: The particular element that the documentation shows was not satisfied; no automatic extension to other elements.

Consequence: Actual effect, duration, loss, causation, cessation and continuing harm, with a source for every entry.

Responsibility: Authority, manager, implementing actor, oversight body and State, distinguished by type of responsibility.

Demand: Cessation, rectification, reconsideration, actual assistance, payment, relevant investigation and safeguards against recurrence.

Closure: Documented implementation and follow-up; a case status or plan alone cannot fill this field.

The source register and the precise evidence requirements make the report subject to verification. The documented charge of repeated known failures is maintained, while each additional individual liability requirement is applied to its own originals.

23 Literature - books and articles

Reference numbers are used throughout the report. U.å. indicates that a reliable publication year has not been established in the text used. Publication details are bibliographical references; no access to a private file archive is required. The report's factual and legal verification sources appear in chapter 24. The evidential status of the book cases appears in chapter 12 and annexes A-B.

[1] Marie Broberg (2025), Magtmisbrug & Forvaltningskultur. edition 1, published 30. September 2025. Publisher: Broberg v. Marie Broberg. Publication details and the author's description of sources: p. 3. Case locations and excerpts: Appendix A.

[2] Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 - entire book.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – p. 7 on accounts and pseudonyms.

[2] Additional direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – book p. 29-31.

[2] Additional direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – book p. 23-27.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – p. 7 of the book.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – book pp. 169-170.

[2] Additional direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – the chapter starting on p. 15.

[2] Additional direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – the chapter starting on p. 23.

[2] Additional direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – the chapter starting on p. 29.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – chapter starting at p. 39.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – the chapter beginning on p. 47.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – chapter starting at p. 63.

[2] Additional direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – the chapter starting on p. 85.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – chapter starting at p. 101.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – the chapter beginning on p. 107.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – chapter starting at p. 119.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – the chapter beginning on p. 129.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – the chapter beginning on p. 135.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – the chapter beginning on p. 153.

[2] Supplementary direct passage: Forlaget Alternativet, De Retsløse (2025), ISBN 978-87-998783-1-4 – the chapter beginning on p. 165.

[3] Ole Bakkestrøm, Umenneskelig sagsbehandling (n.d.).

[4] Ole Bakkestrøm, Justice delayed is justice denied (undated).

[5] Ole Bakkestrøm, Resonans og tab af virkning (n.d.).

[6] Ole Bakkestrøm, Resonans – når mødet bliver regulerende (n.d.).

[7] Ole Bakkestrøm, Mennesket som rytmeorganisme (n.d.).

[8] Ronnie Kristensen, The children have shown us this for years – but we refused to feel it (2025).

[9] Ronnie Kristensen, How much power should doctors, caseworkers and municipal managers have over a person's life? (2025).

[10] Ronnie Kristensen, Small-world: reflections on self-oscillation, resonance, the human being as a mosaic of needs, and human development and decline (2025).

[11] Ronnie Kristensen, When freedom disappears in the name of professionalism (2025).

[12] Ronnie Kristensen, When the body is silenced – a critique of the medical paradigm and the need for a rhythmic understanding of the human being (2025).

[13] Ronnie Kristensen, when narcissism gets power - and the welfare system loses its humanity (2025).

[14] Ronnie Kristensen, Systemic powerlessness and culturally conditioned dissociation – when social culture conflicts with our natural rhythms (undated).

Ronnie Kristensen, developer of Naturnær Menneskelig Udviklingsteori(NMU),is credited for the theory’s concepts. Ole Bakkestrøm’s three educational articles are independent developments of this perspective. The report’s legal accountability chains are independent analyses of the identified legal and oversight sources.

24 Sources - public originals and precise locators

The report's oversight, legal and other documentary sources are collected here. Click the relevant passage to open the publicly available original. Printed page numbers and physical PDF pages are distinguished where necessary. A PDF page fragment is a navigation aid; if the reader ignores it, the stated locator still identifies the passage. Judgment-database fragments identify the case itself. An authority's statement is not in itself independent proof of every event recounted. Historical conduct is assessed under the law in force at the time.

[15] Ankestyrelsen, Report on municipalities' use of the Children's Act § 139, subsections 3 and 4, 2024 (March 2025).

[16] Ankestyrelsen / Borgerrådgiveren, Placement of children and young people (2006) – reporting period 01.01.2006–20.04.2006; printed pp. 11, 14–16 and 52.

[16] Additional direct passage: Appeals Board, Placement of children and young people (2006) – printed p. 11 and 14-16; methodology p. 52.

[17] Appeals Board / Citizens' Adviser, Placement of children and young people (2008) – reporting period 01.01.2006–15.05.2007; Printed p. 9, 12–16, 55–57 and 63–65.

[17] Supplementary direct passage: Ankestyrelsen, Placement of children and young people (2008) – printed pp. 9 and 12-16; methodology pp. 55-57 and 63-65.

[18] Ankestyrelsen / Borgerrådgiveren, Placement of children and young people (2009) – reporting period: latest decisions before 01.01.2009; individual starting date not established; Printed pp. 13–18 and 74; Table 2.2 compared with 2.5.

[18] Additional direct passage: Appeals Board, Placements of children and young people (2009) – printed p. 13-18 and 74; the original's difference between 104 and 105 is retained.

[19] Ankestyrelsen, Child Case Barometer 2020 – pp. 18, 20, 28, 30, 34, 45 and methodology p. 49.

[19] Additional direct passage: Child Welfare Case Barometer 2020, p. 18.

[19] Supplementary direct passage: Child Case Barometer 2020, p. 20.

[19] Supplementary direct passage: Child Case Barometer 2020, p. 28.

[19] Supplementary direct passage: Child Case Barometer 2020, p. 30.

[19] Additional direct passage: Child Welfare Case Barometer 2020, p. 34.

[19] Supplementary direct passage: Child Case Barometer 2020, p. 45.

[20] Ankestyrelsen, Child Case Barometer 2021 – reporting period 2021; printed p. 21; 08.01.2017–08.01.2020.

[20] Additional direct passage: Appeals Board, Child Welfare Case Barometer 2021 – p. 21-22, 31, 33, 37, 47 and methodology p. 51-52.

[20] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2021 – reporting period 2021; printed p. 22; 08.01.2017–08.01.2020.

[20] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2021 – reporting period 2021; Printed p. 31; 08.01.2017–08.01.2020.

[20] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2021 – reporting period 2021; printed p. 33; 08.01.2017–08.01.2020.

[20] Additional direct passage: Appeals Board, Child Welfare Case Barometer 2021 – reporting period 2021; Printed p. 37; 08.01.2017–08.01.2020.

[20] Supplementary direct passage: Child Case Barometer 2021, p. 21.

[20] Additional direct passage: Child Welfare Case Barometer 2021, p. 22.

[20] Supplementary direct passage: Child Case Barometer 2021, p. 31.

[20] Supplementary direct passage: Child Case Barometer 2021, p. 33.

[20] Supplementary direct passage: Child Case Barometer 2021, p. 37.

[20] Supplementary direct passage: Child Case Barometer 2021, p. 47.

[21] Ankestyrelsen, Child Case Barometer 2022 – reporting period 2022; printed pp. 32–33; 11.03.2017–11.03.2020.

[21] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2022 – pp. 22-23, 32-33, 35, 39, 49 and methodology pp. 53-54.

[21] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2022 – reporting period 2022; printed p. 22; 11.03.2017–11.03.2020.

[21] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2022 – reporting period 2022; Printed p. 23; 11.03.2017–11.03.2020.

[21] Additional direct passage: Appeals Board, Child Welfare Case Barometer 2022 – reporting period 2022; Printed p. 35; 11.03.2017–11.03.2020.

[21] Additional direct passage: Appeals Board, Child Welfare Case Barometer 2022 – reporting period 2022; Printed p. 39; 11.03.2017–11.03.2020.

[21] Additional direct passage: Child Welfare Case Barometer 2022, p. 22.

[21] Supplementary direct passage: Child Case Barometer 2022, p. 23.

[21] Supplementary direct passage: Child Case Barometer 2022, p. 32.

[21] Supplementary direct passage: Child Case Barometer 2022, p. 35.

[21] Additional direct passage: Child Welfare Case Barometer 2022, p. 39.

[21] Supplementary direct passage: Child Case Barometer 2022, p. 49.

[22] Ankestyrelsen, Child Case Barometer 2023 – reporting period 2023; printed p. 20; decisions 2021, case processing 2020–2021.

[22] Additional direct passage: Appeals Board, Child Welfare Case Barometer 2023 – p. 20-21, 28, 33, 36, 39 and methodology p. 41-43.

[22] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2023 – reporting period 2023; Printed p. 21; Decisions 2021, case processing 2020–2021.

[22] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2023 – reporting period 2023; Printed p. 28; Decisions 2021, case processing 2020–2021.

[22] Additional direct passage: Appeals Board, Child Welfare Case Barometer 2023 – reporting period 2023; Printed p. 33; Decisions 2021, case processing 2020–2021.

[22] Additional direct passage: Appeals Board, Child Welfare Case Barometer 2023 – reporting period 2023; Printed p. 36; Decisions 2021, case processing 2020–2021.

[22] Additional direct passage: Child Welfare Case Barometer 2023, p. 20.

[22] Additional direct passage: Child Welfare Case Barometer 2023, p. 21.

[22] Supplementary direct passage: Child Case Barometer 2023, p. 28.

[22] Additional direct passage: Child Welfare Case Barometer 2023, p. 33.

[22] Supplementary direct passage: Child Case Barometer 2023, p. 36.

[22] Supplementary direct passage: Child Case Barometer 2023, p. 39.

[23] Ankestyrelsen, Child Case Barometer 2024 – reporting period 2024; Printed pp. 29–30; Decisions 2022, case processing 2021–2022.

[23] Additional direct passage: Appeals Board, Child Welfare Case Barometer 2024 – p. 21-22, 29-30, 34, 37, 40 and methodology p. 42-44.

[23] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2024 – reporting period 2024; Printed p. 21; Decisions 2022, case processing 2021–2022.

[23] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2024 – reporting period 2024; printed p. 22; decisions 2022, case processing 2021–2022.

[23] Additional direct passage: Appeals Board, Child Welfare Case Barometer 2024 – reporting period 2024; Printed p. 34; Decisions 2022, case processing 2021–2022.

[23] Additional direct passage: Appeals Board, Child Welfare Case Barometer 2024 – reporting period 2024; Printed p. 37; Decisions 2022, case processing 2021–2022.

[23] Supplementary direct passage: Child Case Barometer 2024, p. 21.

[23] Supplementary direct passage: Child Case Barometer 2024, p. 22.

[23] Additional direct passage: Child Welfare Case Barometer 2024, p. 29.

[23] Additional direct passage: Child Welfare Case Barometer 2024, p. 34.

[23] Additional direct passage: Child Welfare Case Barometer 2024, p. 37.

[23] Supplementary direct passage: Child Case Barometer 2024, p. 40.

[24] Ankestyrelsen, Child Case Barometer, pilot study (2019) – main findings and methodology; public archive copy.

[25] Ankestyrelsen / Borgerrådgiveren, Flex jobs for people with currently limited work capacity (2016) – reporting period 11.05.2013–16.06.2015, actual decision dates.; printed pp. 2–4, 62–66 and 72–76.

[25] Supplementary direct passage: Ankestyrelsen, Flex jobs for people with currently limited work capacity (2016) – printed pp. 2-4, 62-66 and 72-76.

[25] Additional direct passage: Appeals Board, Flex jobs for citizens with currently limited capacity for work (2016), original methodology – reporting period 11.05.2013–16.06.2015, actual decision dates.; Printed p. 2, physical PDF p. 5..

[26] Ankestyrelsen / Borgerrådgiveren, Moving and returning home of young people in care (2011) – reporting period 01.2010–03.2011; printed pp. 9–12, 40–41 and 57–59; PDF pp. 12–15, 43–44 and 60–62.

[26] Additional direct passage: Appeals Board, Moving and returning home young people in care (2011) – printed p. 9-12, 40-41 and 57-59; PDF p. 12-15, 43-44 and 60-62.

[27] Ankestyrelsen, Disability pension (2015), original methodology – reporting period 01.10.2013–01.04.2014.; Printed p. 2, physical PDF p. 4; case-submission letter: printed p. 53, physical PDF p. 55..

[27] Supplementary direct passage: Ankestyrelsen, Disability pension (April 2015) – Table 1.1, PDF p. 5; other tables on the basis for decisions and legality.

[27] Supplementary direct passage: Ankestyrelsen / Borgerrådgiveren, Disability Pension (2015) – reporting period 01.10.2013–01.04.2014.; table 1.1, PDF p. 5.

[28] Appeals Board / Citizens' Adviser, Disability pension without submission to the rehabilitation team (2019) – reporting period Decisions no earlier than 01.10.2017; most recent cases. No common upper decision date is published in the verified methodology annex.; PDF pp. 6–9 and footnote 1.

[28] Supplementary direct passage: Ankestyrelsen, Disability pension without referral to the rehabilitation team (2019) – main report PDF pp. 6-9 and footnote 1.

[29] Ankestyrelsen / Borgerrådgiveren, Participation of children and parents in cases concerning voluntary measures (2011) – reporting period: latest decisions before 01.02.2010; individual starting date not established; Printed pp. 13–16 and 79–81; PDF pp. 17–20 and 83–85.

[29] Additional direct passage: Appeals Board, Involvement of children and parents in cases concerning voluntary measures (2011) – printed pp. 13-16 and 79-81; PDF pp. 17-20 and 83-85.

[30] Ankestyrelsen, Municipal assessment of young people under 30 (2015), original methodology – reporting period: first contact after 01.01.2014; assessment period completed before 01.06.2014. Most recent assessments working backwards from the cut-off date.; printed/PDF p. 2, methodology p. 48, request letter pp. 74–76..

[30] Additional direct passage: Appeals Board, Municipal classification of young people under 30 (2015) – main findings; printed p. 3-4; methodology and case-request letter p. 74-75.

[30] Additional direct passage: Appeals Board / Citizens' Adviser, Municipal classification of young people under 30 (2015) – reporting period First contact after 01.01.2014; classification period completed before 01.06.2014. Most recent classifications backwards from the cut-off date.; Printed pp. 3–4 and 74–75.

[31] Ankestyrelsen / Borgerrådgiveren, Use of force against people with dementia (2015) – reporting period most recent decisions before 31.12.2014, then working backwards; no common earliest decision date specified in the request.; printed pp. 6–10, 118; methodology PDF pp. 116–118 and 149.

[31] Supplementary direct passage: Ankestyrelsen, Use of force against people with dementia (2015) – printed pp. 6-10, 118 and methodology PDF pp. 116-118 and 149.

[32] Ankestyrelsen, Reassessment and extension of the sickness benefit period (2015), original methodology – reporting period: most recent decisions made before 15.04.2015 under expanded case-request criteria; no common earliest decision date is specified in the methodology section.; methodology printed pp. 71–72, physical PDF pp. 72–73; revised request letter printed p. 124, PDF p. 125..

[32] Supplementary direct passage: Ankestyrelsen, Reassessment and extension of the sickness benefit period (2015) – printed pp. 32-34, 70-73 and 117-124.

[32] Supplementary direct passage: Ankestyrelsen / Borgerrådgiveren, Reassessment and extension of the sickness benefit period (2015) – reporting period: latest decisions made before 15.04.2015 under expanded case-submission criteria; no common earliest decision date is specified in the methodology section.; Printed pp. 32–34, 70–73 and 117–124.

[33] Ankestyrelsen, Processing times in adult disability cases (June 2022) – pp. 4-7 on methodology and case histories; pp. 32-45 on time and support; pp. 69-74 on Ankestyrelsen.

[34] Appeals Board, Rare disabilities and acquired brain injury (2015) – main findings and tables on information, assistance and guidance on appeals.

[35] Ankestyrelsen, Assessment of material from the Ministry of Foreign Affairs on the facilitation of adoptions from South Korea to Denmark in the 1970's and 1980's, 10. September 2024, case no. 24-53940.

[36] Ankestyrelsen, The year in review – focused supervision in the social sector in 2024 (February 2025).

[37] Appeals Board, Annual report 2025 – p. 8-11.

[38] Children's Act, Consolidation Act no. 282 of 17. March 2025 – §§ 100 and 102 on a child's return home and the return-home period.

[39] CPT/Inf (2008) 26, report on the visit to Denmark in February 2008 - paragraphs 4-6, 10 and 15.

[40] CPT/Inf (2013) 11, Denmark's response of 3. July 2013 - responses concerning solitary confinement, visits and restraint.

[41] CPT / Inf (2013) 3, Report on the visit to Greenland in September 2012 - points 6-8 and 45-49.

[42] CPT/Inf (2014) 25, report on the visit to Denmark in February 2014 – paragraphs 5 and 115 and summary pp. 6-8.

[43] CPT/Inf (2015) 16, Denmark's response – response to paragraphs 5 and 9; printed pp. 1-3.

[44] CPT / Inf (2019) 35, Report on the visit to Denmark in April 2019 - Summary, points 111, 117 and 174.

[45] CPT / Inf (2024) 38, Report on the visit to Denmark in May-June 2024 - paragraphs 73 and 143-147.

[46] CPT/Inf (2025) 19, Denmark's response – response to paragraphs 111 and 148; printed pp. 67-68, 84 and 99-100.

[47] Danish Association of Social Workers, Memorandum on unlawful decisions, September 2024 – the survey's questions concerning unlawful decisions and causes.

[48] Data Protection Agency, Annual Report 2010 - printed p. 11 and 18-21.

[49] European Convention on Human Rights – Articles 1, 2, 3, 8 and 13.

[49] Supplementary direct passage: European Convention on Human Rights – Article 46.

[50] Psychiatric Appeal Board, Annual Report 2025 - p. 7-9, Figure 1-3.

[51] Det Psykiatriske Patientklagenævn, annual report 2025 – reporting period 2024; p. 15, figure 3, separate category.

[51] Supplementary direct passage: Det Psykiatriske Patientklagenævn, Annual report 2025 – pp. 7-9, 15-18 and 20-21; Tables 2, 3, 11 and 12.

[51] Supplementary direct passage: Det Psykiatriske Patientklagenævn, annual report 2025 – reporting period 2023; pp. 15-19, tables 9 and 12.

[51] Additional direct passage: Psychiatric Patient Complaints Board, annual report 2025 – reporting period 2024; p. 15-19, table 9 and 12.

[51] Supplementary direct passage: Det Psykiatriske Patientklagenævn, annual report 2025 – reporting period 2025; pp. 15-19, tables 9 and 12.

[51] Supplementary direct passage: Psychiatric Patient Complaints Board, annual report 2025 – reporting period 2025; p. 15, figure 3 and prose.

[51] Supplementary direct passage: Det Psykiatriske Patientklagenævn, annual report 2025 – reporting period 2025; p. 19, table 12.

[52] ECtHR, Abdulaal Naser and Others v. Denmark, 46571/22, 21. October 2025 – the judgment's reasoning.

[53] ECtHR, Guide on Article 13 – paragraphs 146-156, physical PDF pp. 43-44; Kudła, Sürmeli and Scordino on duration and remedies.

[53] Supplementary direct passage: ECtHR, Guide on Article 13.

[54] ECtHR, Guide on Article 2.

[55] ECtHR, Gäfgen v. Germany, Grand Chamber, 22978/05, 1. June 2010 – paragraphs 88-89 and 123-125.

[56] ECtHR, Strand Lobben and Others v. Norway, Grand Chamber, 37283/13, 10. September 2019 – paragraphs 205, 208 and 212.

[57] ECtHR, Z and Others v. the United Kingdom, Grand Chamber, 29392/95, 10. May 2001 – particularly paragraphs 73-75.

[58] Liability for Damages Act, Consolidation Act no. 1080 of 30. August 2025 – section 23.

[59] EU Charter of Fundamental Rights, 2016 version.

[60] UN Committee on the Rights of the Child, Concluding observations on Denmark (2011) – paragraphs 41-46 and 70.

[61] UN International Law Commission, Responsibility of States for Internationally Wrongful Acts (2001) – Articles 2-7, 12-15, 29-41 and 55; physical PDF pp. 1-10 and 15.

[61] Additional direct passage: UN International Law Commission, Articles on Responsibility of States for Internationally Wrongful Acts (2001) – Article 2, 4, 7, 30 and 31.

[62] UN Committee on the Rights of Persons with Disabilities, Concluding observations on Denmark (2024) – sections on family life, support for parents with disabilities and children.

[63] UN Committee on Economic, Social and Cultural Rights, Denmark (2013) - paragraphs 4, 13, 15, 17-18 and 26.

[64] UN Committee on Economic, Social and Cultural Rights, Denmark (2019) – paragraphs 41-44, 51-57 and 76-77.

[65] UN Committee on the Elimination of Racial Discrimination, Denmark (2021) – paragraphs 4-9, 18-21, 28, 36 and 42-44.

[66] UN Committee against Torture, CAT/C/DNK/CO/8 (2023) – point 40-41 and 48-49.

[67] Parliamentary Ombudsman, FOB 2010-4-4, Record-keeping and responsibility, 25. October 2010 – FOB 2010-4-4, particularly p. 1-2.

[68] Folketingets Ombudsmand, FOB 2018-33 – Return home of children in care – sections on the four return-home cases and the missing conversation and action plan.

[69] Parliamentary Ombudsman, A municipality’s use of a function in an IT system may cast doubt on information in cases concerning children and young people, 27. March 2026.

[70] Inquiry leadership, Report concerning Thorkild Fogde, 10. February 2023, part 8 – published recommendation and reasons.

[71] Public Administration Act, Consolidation Act no. 433 of 22. April 2014 – §§ 19 and 22-25.

[72] Commission of Inquiry into the Mink Culling Case, Report (2022), volume 2 – chapter 8; printed pp. 632-650, 657-717 and 727-748.

[73] Supreme Court, Judgment of 2. September 2025, BS-58021/2023-HJR – the judgment’s assessment of evidence and outcome.

[74] Supreme Court, Judgment of 21. August 2026, BS-36329/2025-HJR – pp. 1-7.

[75] Højesteret, Judgment of 31. May 2022, cases 134/2018 and 141/2018 – Green Desert – statement of facts and reasoning.

[76] Ministry of the Interior and Health, Langeland Municipality’s case processing in the Family Department, 29. May 2026, case no. 2025-11404 – pp. 1-4 and 14-16.

[77] Jensen, Tenna et al., Independent investigation of contraceptive practices in Kalaallit Nunaat during the period 1960-1991 (2025) – sections on accounts, events, consent and time.

[78] Minister of Justice’s statement on report 16/2025, 14. September 2026.

[79] Minister of Justice’s supplementary statement concerning report 16/2025, 28. September 2026.

[80] Minister of Justice’s reply to REU question 1157, 23. June 2025 – pp. 2-3 on UTH information in prison healthcare.

[81] Ministry of Justice, Implementation annex to the statement of 14. September 2026.

[82] Ministry of Justice, Revocation of a warning to Anne-Mette Lyhne Jensen (2023) – reasons for the decision.

[83] Ministry of Justice, Withdrawal of the reprimand of Johan Legarth (2023) – reasons for the decision.

[84] Ankestyrelsen / Borgerrådgiveren, Citizens’ Adviser: Own-initiative investigation into case processing in the children’s field (24.05.2017) – reporting period 2013–2016; printed pp. 6–8, 12–14, 66–69 and 74–75.

[84] Supplementary direct passage: Copenhagen Citizens' Adviser, The quality of case processing and exercise of public authority in Borgercenter Børn og Unge, 24. May 2017 – pp. 6-8, 12-14, 66-69 and 74-75.

[85] Københavns Byret, Reasons and sentencing in the Tibet case, 1. November 2023 – published judgment excerpt, PDF pp. 7-8.

[86] Landsskatteretten, Annual report 2013, 4. March 2014 – PDF p. 5; performance targets and case-processing time.

[87] Board of Equal Treatment, KEN no. 9536, 17. June 2021, case no. 19-16769 – printed pp. 1 and 12-14; PDF pp. 2 and 13-15.

[88] Act no. 722 of 1. September 2026 concerning the compensation scheme for the contraception case - sections 4 and 16.

[89] Local Government Act, consolidated Act no. 13 of 5. January 2026 – §§ 48-50 d on supervision and responses.

[89] Supplementary direct passage: Local Government Act, Consolidation Act no. 13 of 5. January 2026 – sections 47-50 d, 53 a-54 and 61; PDF pp. 11-14.

[90] Ministry of the Environment, Employment law follow-up on the Mink Commission's report, 24. August 2022 – the ministry's follow-up decision.

[91] Patient Compensation, Treatment injuries 2025, 27. May 2026 – reporting period 2021; table 3-4, p. 3-7.

[91] Supplementary direct passage: Patienterstatningen, Treatment Injuries 2025, version 27. May 2026 – PDF pp. 2-9.

[91] Supplementary direct passage: Patienterstatningen, Treatment injuries 2025, 27. May 2026 – reporting period 2022; tables 3-4, pp. 3-7.

[91] Supplementary direct passage: Patienterstatningen, Treatment Injuries 2025, 27. May 2026 – reporting period 2023; tables 3-4, pp. 3-7.

[91] Supplementary direct passage: Patienterstatningen, Treatment injuries 2025, 27. May 2026 – reporting period 2024; tables 3-4, pp. 3-7.

[91] Additional direct passage: Patient Compensation Association, Treatment injuries 2025, 27. May 2026 – reporting period 2025; table 3-4, p. 3-7.

[92] Patienterstatningen, Compensation for women for contraception in Greenland – scheme and current implementation status.

[93] Patienterstatningen, Pharmaceutical Injuries 2025, version 27. May 2026 - PDF pp. 2-5.

[94] Patientforsikringen, Annual review 2007 – printed pp. 12 and 14-15; PDF pp. 7-8.

[95] Patientforsikringen, Annual review 2008 – printed p. 6; PDF p. 4.

[96] PET and FE, Joint statement, 2. September 2025 – acknowledgement following the Supreme Court judgment.

[97] Legal Protection and Administration in Social Matters Act, consolidated Act no. 680 of 3. August 2026 – §§ 3, 3 a, 5, 10 and 52.

[98] National Police, Disciplinary Case Summary 2006 - public document copy hosted by KRIM - nos. 11, 15, 26-27 and 73.

[99] National Police, Disciplinary Case Summary 2007 - public document copy hosted by KRIM - nos. 11 and 31.

[100] National Police, Disciplinary case summary 2011 – no. 61; PDF p. 12-13.

[101] Rigspolitiet, Disciplinary case summary 2014 – no. 32; PDF p. 9.

[102] National Police, Disciplinary Case Summary 2015 - no. 21; PDF p. 7.

[103] National Police, Revocation of two disciplinary warnings, 2. June 2023 – the National Police's decision.

[104] Court of Impeachment, Judgment of 13. December 2021 – pp. 112-118, 138-142 and 145-149.

[105] National Audit Office, Closing note C108/25 on the Appeals Board's case-processing times (2025) – entire note.

[106] National Audit Office, The Appeals Board’s supervision and use of responses to breaches of law, report 18/2024, 2. June 2025 – figure 5, table 1 and annex B-C; printed p. 16, 26 and 36-37.

[106] Supplementary direct passage: Rigsrevisionen, Ankestyrelsen's supervision and use of responses to breaches of the law, Report 18/2024, 2. June 2025 – Figure 5, Table 1 and Annexes A-B; printed pp. 16, 26 and 36-37.

[107] National Audit Office, Report 10/2023 on compliance with the right to diagnostic assessment for children and young people in psychiatry, 19. February 2024 – main findings, figures and methodology annex; printed p. 31 ff..

[108] Rigsrevisionen, Report 17/2024 on specialised palliative care, 12. May 2025 – summary and waiting-time figures.

[109] Rigsrevisionen, Follow-up on report 10/2023 concerning the right to assessment in child and adolescent psychiatry, 26. November 2025 – the complete follow-up memorandum.

[110] National Audit Office, Police closure of cases concerning offences against the person, report 16/2025, 11. May 2026 – main findings, case review and methodology.

[111] Rigsrevisionen, Police discontinuance of financial crime cases, report 15/2025, 11. May 2026 – main findings and methodology of the respondent survey.

[112] Rigsrevisionen, Case processing in child placements, Report 11/2025, 9. April 2026 – reporting period: first placements 2022–2024; follow-up in the main investigation 2021–2024; Statsrevisorerne's remarks, principal findings and methodology.

[112] Supplementary direct passage: Rigsrevisionen, Case Processing in Child Placements, report 11/2025, 9. April 2026 – Statsrevisorerne’s remarks, PDF pp. 4-6; main findings and methodology, first placements 2022-2024.

[113] Schultz-Knudsen, Mikele and Eiriksson, Birgitte Arent, Pre-trial detention – Legal safeguards before judgment, Justitia (2025) – statistics on duration and acquittal of the principal charge.

[114] Skatteankestyrelsen, Figures from Skatteankestyrelsen 2025 – table of closed cases and outcomes.

[114] Additional direct passage: Tax Appeals Agency, case statistics 2025 – reporting period 2025; PDF p. 9.

[114] Supplementary direct passage: Skatteankestyrelsen, Figures from Skatteankestyrelsen 2025 – reporting period 2025; p. 9, table 4.

[115] Statelessness Commission, Report (2015), volume 8 – case review and case 696.

[116] Statelessness Commission, Report (2015), volume 9 – printed pp. 2736-2747, 2752-2755 and the specific case assessments.

[117] The Prime Minister, Revocation of Disciplinary Warning, 23 March 2023 - Statement of reasons for the decision.

[118] Criminal Code, Consolidation Act no. 1294 of 7. November 2025 – §§ 81, point 8, and 155-157, and § 27, subsection 2.

[119] Styrelsen for Patientsikkerhed, Authorisation of psychologists.

[120] Danish Patient Safety Authority, Danish Patient Safety Database, Annual report 2024 – tables on individual reports, aggregate reporting and potential consequences.

[121] Health Act, Consolidation Act no. 248 of 8. March 2023 – sections 201-202 on reporting adverse incidents.

[122] Disciplinary Board of Health Services, Annual Report 2025 - p. 6-8 and 15-18; Figure 1-5.

[123] Task Force, Analysis report – Langeland Municipality (March 2023) – p. 6 and 29-33.

[124] Task Force, Analysis report – Nordfyns Kommune (October 2020) – sections on financial management, insufficient intervention and the investigation backlog.

[125] Task Force, Status report – Faaborg-Midtfyn Municipality (March 2020) – management statements concerning staff reductions, delayed assistance and follow-up.

[126] Tibet Commission, Report (2017), volume 2 – chapters on interventions and incorrect information.

[127] Tibet Commission, Report (2022), volume 2 – printed p. 987 and chapter 9.7, pp. 1110-1130.

[128] Immigration Appeals Board, Annual report 2025 – PDF p. 6 on criticism and reconsideration; historical statistics sections.

[129] Vestre Landsret, Judgment of 25. February 2010, S-1566-09, AM 2010.02.25V2 – Suldrup – combined judgment file with administrative decisions and district court judgment.

[130] VIVE and EVA, Quality in daycare – national survey of municipal daycare institutions for children aged 3-5 (2025).

[131] Østre Landsret, Judgment of 28. May 2025, BS-4484/2012-OLR – pp. 4-9 and 124-129.

[132] Eastern High Court, Judgment of 29. October 2025, S-3118-23 – the Tibet case – Domsdatabasen, case 10805; the judgment's p. 1-21, including decision and sentence.

[133] Agency for Modernisation, KL and Danish Regions, Good conduct in the public sector (December 2017) – chapter 2, printed p. 9-11, PDF p. 10-12.

[134] Parliamentary Ombudsman, FOB 2019-2, 22. January 2019 – five employment cases and criticism of the municipality's overall handling.

[135] Parliamentary Ombudsman, FOB 2026-4, 3. February 2026 – pp. 3-5 and 17-19, including subsequent municipal follow-up.

[136] ECtHR, Aggerholm v. Denmark, 45439/18, 15. September 2020 – the Court Registry's official judgment press release ECHR 256 (2020), physical PDF pp. 1-3; Article 3 and continued belt restraint.

[136] Additional direct passage: ECtHR, Judgment Aggerholm v. Denmark, 15.9.2020 – reporting period 2020-09-15; Conclusion and reasoning concerning continued restraint; Official judgment summary by the ECtHR Registry.

[137] ECtHR, Aggerholm v. Denmark, 45439/18, 15. September 2020 – original judgment entry in HUDOC; the factual account here is directly supported by the official judgment press release.

[138] UN Human Rights Committee, General Comment No. 31, CCPR/C/21/Rev.1/Add.13, adopted 29. March 2004 – paragraphs 4, 8 and 14-20; public Spanish treaty-body text.

[139] Vienna Convention on the Law of Treaties (1969) – Articles 26-27 and 31, physical PDF pp. 11-12.

[140] UN, World Summit 2005 – A/RES/60/1, adopted 16. September 2005, paragraphs 138-139 reproduced on the UN's official summit page.

[141] UN Secretary-General, Implementing the responsibility to protect, A/63/677, 12. January 2009 – paragraphs 3, 10-11 and 13-14; physical PDF pp. 5 and 7-9.

[142] UN, Rome Statute of the International Criminal Court, corrected original text (1998) – Articles 7, 17, 25, 27-28 and 30; the provisions used here, rather than the original outdated aggression provision.

[143] Ankestyrelsen, Appeal Statistics for the Social Appeals Boards 2006, historical official publication in a public web archive – reporting period 2006; table 1 p. 6; table 3 p. 11; table 4 p. 14.

[144] Appeals Board, Appeal statistics 2011 – reporting period 2007; table 2.1, physical PDF p. 5; retrospective annual outcomes.

[144] Supplementary direct passage: Ankestyrelsen, Appeal statistics 2011 – reporting period 2008; table 2.1, physical PDF p. 5; retrospective annual outcomes.

[144] Additional direct passage: Appeals Board, Appeal statistics 2011 – reporting period 2009; table 2.1, physical PDF p. 5; retrospective annual outcomes.

[144] Supplementary direct passage: Ankestyrelsen, Appeal statistics 2011 – reporting period 2010; table 2.1, physical PDF p. 5; retrospective annual outcomes.

[144] Supplementary direct passage: Ankestyrelsen, Appeal Statistics 2011 – reporting period 2011; table 2.1, physical PDF p. 5; retrospective annual outcomes.

[145] Ankestyrelsen, Appeal Statistics 2012, historical official publication in a public web archive – reporting period 2012; table 2.1, printed p. 4, PDF p. 6; table 3.1, printed p. 8, PDF p. 10; table 3.2, printed pp. 9–10, PDF pp. 11–12.

[146] Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2014; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[146] Supplementary direct passage: Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2015; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[146] Supplementary direct passage: Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2016; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[146] Supplementary direct passage: Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2017; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[146] Supplementary direct passage: Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2018; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[146] Supplementary direct passage: Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2019; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[146] Supplementary direct passage: Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2020; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[146] Supplementary direct passage: Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2021; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[146] Supplementary direct passage: Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2022; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[146] Supplementary direct passage: Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2023; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[146] Supplementary direct passage: Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2024; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[146] Supplementary direct passage: Ankestyrelsen, Statistics Portal, municipal appeals, extract checked on 11. October 2026 – reporting period 2025; Municipalities; whole country/total; all 26 selected legislative groups; outcomes on the merits; amended/annulled and remitted.

[147] Statsforvaltningen, Annual report 2013 – reporting period 1. January–30. June 2013; Table 19, printed p. 26, physical PDF p. 28; periods: printed p. 2, physical PDF p. 4.

[148] Ankestyrelsen, Annual Report 2013, historical official original in a public web archive – reporting period: transferred municipal appeal fields from 1. July 2013; printed and physical PDF pp. 7–8; previous two instances pp. 20–21.
[149] Psychiatric Patient Complaints Board, Annual Report 2013 - Review Period 2011; s. 17 -22.

[149] Supplementary direct passage: Psychiatric Patient Complaints Board, annual report 2013 – reporting period 2012; pp. 17-22.

[149] Additional direct passage: Psychiatric Patient Complaints Board, annual report 2013 – reporting period 2013; p. 17-22.

[150] Psychiatric Patient Complaints Board, annual report 2014 – reporting period 2014; p. 20-24.

[151] Det Psykiatriske Patientklagenævn, annual report 2017 – reporting period 2015; pp. 21-23, table 11 and separate text on duration.

[151] Additional direct passage: Psychiatric Patient Complaints Board, annual report 2017 – reporting period 2016; p. 21-23, table 11 and separate text on duration.

[151] Additional direct passage: Psychiatric Patient Complaints Board, annual report 2017 – reporting period 2017; p. 21-23, table 11 and separate text on duration.

[151] Supplementary direct passage: Det Psykiatriske Patientklagenævn, annual report 2017 – reporting period 2017; p. 23, explicitly excluded from the statistics.

[152] Psychiatric Patient Complaints Board, annual report 2018 - reporting period 2018; pp. 9-12.

[153] Det Psykiatriske Patientklagenævn, annual review 2019 – reporting period 2019; pp. 11-14.

[154] Psychiatric Patient Complaints Board, Annual Report 2022 - review period 2020; s. 11 -18.

[154] Supplementary direct passage: Psychiatric Patient Complaints Board, annual report 2022 – reporting period 2021; pp. 11-18.

[154] Additional direct passage: Psychiatric Patient Complaints Board, annual report 2022 – reporting period 2022; p. 11-18.

[155] Psychiatric Patient Complaints Board, annual report 2010 North Jutland - reporting period 2008; pp. 4-12.

[155] Supplementary direct passage: Psychiatric Patient Complaints Board, annual report 2010 North Jutland – reporting period 2009; pp. 4-12.

[155] Supplementary direct passage: Psychiatric Patient Complaints Board, annual report 2010 North Jutland – reporting period 2010; pp. 4-12.

[156] Psychiatric Patient Complaints Board, annual report 2011 Central Jutland - reporting period 2009; pp. 8-10, 15-16, 19.

[156] Supplementary direct passage: Psychiatric Patient Complaints Board, annual report 2011 Midtjylland – reporting period 2010; pp. 8-10, 15-16, 19.

[157] Psychiatric Patient Complaints Board, annual report 2012 Capital Region - reporting period 2010; pp. 9-10, 16-19.

[158] Director of Public Prosecutions' 2011 report – reporting period 2006; table 4 (conduct), printed p.135 table 4 b.

[158] Supplementary direct passage: Director of Public Prosecutions' 2011 report – reporting period 2007; table 4 (conduct), printed p.135 table 4 b.

[158] Supplementary direct passage: Director of Public Prosecutions' 2011 report – reporting period 2008; table 4 (conduct), printed p.135 table 4 b.

[158] Supplementary direct passage: Director of Public Prosecutions' 2011 report – reporting period 2009; table 4 (conduct), printed p.135 table 4 b.

[158] Supplementary direct passage: Director of Public Prosecutions' 2011 report – reporting period 2010; table 4 (conduct), printed p.135 table 4 b.

[158] Supplementary direct passage: Rigsadvokaten's 2011 report – reporting period 2011; table 4 (conduct), Printed p.135 table 4 b.

[159] Den Uafhængige Politiklagemyndighed, annual report 2012 – reporting period 2012; table 4 (conduct), PDF pages 39,40,41.

[160] Den Uafhængige Politiklagemyndighed, annual report 2013 – reporting period 2013; table 4 (conduct), PDF pages 43,44,45.

[161] Independent Police Complaints Authority, annual report 2014 – reporting period 2014; table 4 (conduct), PDF pages 43,44,45.

[162] Den Uafhængige Politiklagemyndighed, annual report 2015 – reporting period 2015; table 4 (conduct), PDF pages 47,48,49.

[163] Independent Police Complaints Authority, annual report 2016 – reporting period 2016; table 4 (conduct), PDF pages 54,55,57.

[164] Independent Police Complaints Authority, annual report 2017 – reporting period 2017; table 4 (conduct), PDF pages 55,56,58.

[165] Independent Police Complaints Authority, annual report 2018 – reporting period 2018; table 4 (conduct), PDF pages 57,58,60.

[166] Independent Police Complaints Authority, annual report 2019 – reporting period 2019; table 4 (conduct), PDF pages 65,66,68.

[167] Independent Police Complaints Authority, annual report 2020 – reporting period 2020; table 4 (conduct), PDF pages 56,57,58,60.

[168] Independent Police Complaints Authority, annual report 2021 – reporting period 2021; table 4 (conduct), PDF pages 62,63,64,66.

[169] Den Uafhængige Politiklagemyndighed, annual report 2022 – reporting period 2022; table 4 (conduct), PDF pages 112,113,114,116.

[170] Independent Police Complaints Authority, annual report 2023 – reporting period 2023; table 4 (conduct), PDF pages 93,94,95,97.

[171] Den Uafhængige Politiklagemyndighed, annual report 2024 – reporting period 2024; table 4 (conduct), PDF pages 124,125,126,128.

[172] Den Uafhængige Politiklagemyndighed, annual report 2025 – reporting period 2025; table 4 (conduct), PDF pages 121,122,123,125.

[173] National Police/Director of Public Prosecutions, Complaints about police operational decisions 2019 – reporting period 2019; p. 4-5, figure 2.

[174] National Police/Director of Public Prosecutions, Complaints about Police Actions 2020 - reporting period 2020; pp. 4-5, figure 2.

[175] Patient complaint/disciplinary statistics 2006 – reporting period 2006; p. 11, table 6.

[176] Patient complaint/disciplinary statistics 2011 – reporting period 2011; p. 8-9, table 1.

[177] Patient complaint/disciplinary statistics 2012 – reporting period 2012; p. 8-10, table 1.

[178] Patientombuddet/Patient Complaints System statistics 2011 – reporting period 2011; statistics section on criticism of treatment providers.

[178] Supplementary direct passage: Patient complaint/disciplinary statistics 2014 – reporting period 2014; pp. 34-36.

[178] Additional direct passage: Patient Ombudsman/Patient Complaints System statistics 2012 – reporting period 2012; statistics section on criticism of treatment facilities.

[178] Supplementary direct passage: Patientombuddet/patient complaints system statistics 2013 – reporting period 2013; statistics section on criticism of treatment facilities.

[178] Additional direct passage: Patient Ombudsman/Patient Complaints System statistics 2014 – reporting period 2014; statistics section on criticism of treatment facilities.

[179] Patient Ombudsman/Patient Complaints System statistics 2015 – reporting period 2015; statistics section on criticism of treatment facilities.

[179] Supplementary direct passage: Patient complaint/disciplinary statistics 2015 – reporting period 2015; pp. 7-9, tables 4-6.

[180] Patient Ombudsman/Patient Complaints System statistics 2016 – reporting period 2016; statistics section on criticism of treatment facilities.

[180] Additional direct passage: Patient complaint/disciplinary statistics 2016 – reporting period 2016; p. 8-16.

[181] Patient Ombudsman/Patient Complaints System statistics 2017 – reporting period 2017; statistics section on criticism of treatment facilities.

[181] Additional direct passage: Patient complaint/disciplinary statistics 2017 – reporting period 2017; p. 8, table 5.

[182] Danish Agency for Patient Complaints, STPK in figures; register version 5. October 2026 – reporting period 2021; filters disciplinary board cases, decision year 2021.

[182] Additional direct passage: Danish Agency for Patient Complaints, STPK in figures; register version 5. October 2026 – reporting period 2022; filters disciplinary board cases, decision year 2022.

[182] Additional direct passage: Danish Agency for Patient Complaints, STPK in figures; register version 5. October 2026 – reporting period 2023; filters disciplinary board cases, decision year 2023.

[182] Supplementary direct passage: Danish Agency for Patient Complaints, STPK in figures; register version 5. October 2026 – reporting period 2024; filters: disciplinary board cases, decision year 2024.

[182] Additional direct passage: Danish Agency for Patient Complaints, STPK in figures; register version 5. October 2026 – reporting period 2025; filters disciplinary board cases, decision year 2025.

[182] Supplementary direct passage: STPK in figures; register version 5. October 2026 – reporting period 2021; filters complaints concerning courses of treatment, decision year 2021.

[182] Supplementary direct passage: STPK in figures; register version 5. October 2026 – reporting period 2022; filters: complaints about treatment processes, decision year 2022.

[182] Additional direct passage: STPK in figures; register version 5. October 2026 – reporting period 2023; filters care-pathway complaints, decision year 2023.

[182] Supplementary direct passage: STPK in figures; register version 5. October 2026 – reporting period 2024; filters: complaints about treatment processes, decision year 2024.

[182] Additional direct passage: STPK in figures; register version 5. October 2026 – reporting period 2025; filters care-pathway complaints, decision year 2025.

[183] Skatteankestyrelsen, case statistics 2014 – reporting period 2014; PDF p. 4.

[184] Tax Appeals Agency, case statistics 2015 – reporting period 2015; PDF p. 8.

[185] Skatteankestyrelsen, case statistics 2016 – reporting period 2016; PDF p. 12.

[186] Skatteankestyrelsen, case statistics 2017 – reporting period 2017; PDF p. 10.

[187] Skatteankestyrelsen, case statistics 2018 – reporting period 2018; PDF p. 12.

[188] Skatteankestyrelsen, case statistics 2019 – reporting period 2019; PDF p. 11.

[189] Tax Appeals Agency, case statistics 2020 – reporting period 2020; PDF p. 9.

[190] Skatteankestyrelsen, case statistics 2021 – reporting period 2021; PDF p. 8.

[191] Tax Appeals Agency, case statistics 2022 – reporting period 2022; PDF p. 8.

[192] Skatteankestyrelsen, case statistics 2023 – reporting period 2023; PDF p. 8.

[193] Skatteankestyrelsen, case statistics 2024 – reporting period 2024; PDF p. 8.

[194] Immigration Appeals Board, annual report 2013 – reporting period 2013;) p.203.

[194] Supplementary direct passage: Immigration Appeals Board, annual report 2013 – reporting period 2013;) p.204.

[195] Immigration Appeals Board, annual report 2014 – reporting period 2014;) p.334.

[196] Immigration Appeals Board, annual report 2015 – reporting period 2015;) p.361.

[197] Immigration Appeals Board, annual report 2016 – reporting period 2016;) p.283.

[198] Immigration Appeals Board, annual report 2017 – reporting period 2017;) p.391.

[199] Udlændingenævnet, annual report 2018 – reporting period 2018;) p.417.

[199] Supplementary direct passage: Immigration Appeals Board, annual report 2018 – reporting period 2018;) p.418.

[200] Udlændingenævnet, annual report 2019 – reporting period 2019;) p.480.

[200] Additional direct passage: Immigration Appeals Board, annual report 2019 – reporting period 2019;) p.481.

[201] Udlændingenævnet, annual report 2020 – reporting period 2020;) p.791.

[201] Supplementary direct passage: Immigration Appeals Board, annual report 2020 – reporting period 2020;) p.792.

[201] Supplementary direct passage: Udlændingenævnet, annual report 2020 – reporting period 2020;) p.793.

[202] Udlændingenævnet, annual report 2021 – reporting period 2021;) p.717.

[202] Additional direct passage: Immigration Appeals Board, annual report 2021 – reporting period 2021;) p.718.

[202] Supplementary direct passage: Immigration Appeals Board, annual report 2021 – reporting period 2021;) p.719.

[203] Parliamentary Ombudsman, report and annual statistics 2006 – reporting period 2006; statistics section, specified source pages 30.

[204] Folketingets Ombudsmand, report and annual statistics 2007 – reporting period 2007; statistics section, specified source pages 30.

[205] Parliamentary Ombudsman, report and annual statistics 2008 – reporting period 2008; statistics section, specified source pages 30.

[206] Parliamentary Ombudsman, report and annual statistics 2009 – reporting period 2009; statistics section, specified source pages 97.

[207] Parliamentary Ombudsman, report and annual statistics 2010 – reporting period 2010; statistics section, specified source pages 68/76.

[208] Folketingets Ombudsmand, report and annual statistics 2011 – reporting period 2011; statistics section, specified source pages 94/102.

[209] Parliamentary Ombudsman, report and annual statistics 2012 – reporting period 2012; statistics section, specified source pages 86/94.

[210] Folketingets Ombudsmand, report and annual statistics 2013 – reporting period 2013; statistics section, specified source pages 113.

[211] Parliamentary Ombudsman, report and annual statistics 2014 – reporting period 2014; statistics section, specified source pages 108.

[212] Folketingets Ombudsmand, report and annual statistics 2015 – reporting period 2015; statistics section, specified source pages 117.

[213] Parliamentary Ombudsman, report and annual statistics 2016 – reporting period 2016; statistics section, specified source pages 125.

[214] Parliamentary Ombudsman, report and annual statistics 2017 – reporting period 2017; statistics section, specified source pages 103.

[215] Folketingets Ombudsmand, report and annual statistics 2018 – reporting period 2018; statistics section, specified source pages 103.

[216] Parliamentary Ombudsman, report and annual statistics 2019 – reporting period 2019; statistics section, specified source pages 110.

[217] Parliamentary Ombudsman, report and annual statistics 2020 – reporting period 2020; statistics section, specified source pages 85.

[218] Folketingets Ombudsmand, report and annual statistics 2021 – reporting period 2021; statistics section, specified source pages 77.

[219] Parliamentary Ombudsman, report and annual statistics 2022 – reporting period 2022; statistics section, specified source pages 83.

[220] Parliamentary Ombudsman, report and annual statistics 2023 – reporting period 2023; public annual online table, total in the criticism/recommendation etc. group.

[221] Parliamentary Ombudsman, report and annual statistics 2024 – reporting period 2024; public annual web table, total in the criticism/recommendation etc. category.

[222] Folketingets Ombudsmand, report and annual statistics 2025 – reporting period 2025; public annual web table, total in the criticism/recommendation etc. group.

[223] ECtHR, Violations by Article and State 2006 – reporting period 2006; Denmark row, physical PDF p. 106, printed p. 107, table “Violations by Article and by country (2006)”, Denmark.

[224] ECtHR, Violations by Article and State 2007 – reporting period 2007; Denmark row, physical PDF p. 142, the table »Violations by Article and by country (2007)«, Denmark.

[225] ECtHR, Violations by Article and State 2008 – reporting period 2008; Denmark row, p. 1, Denmark.

[226] ECtHR, Violations by Article and State 2009 – reporting period 2009; Denmark row, p. 1, Denmark.

[227] ECtHR, Violations by Article and State 2010 – reporting period 2010; Denmark row, p. 1, Denmark.

[228] ECtHR, Violations by Article and State 2011 – reporting period 2011; Denmark row, p. 1, Denmark.

[229] ECtHR, Violations by Article and State 2012 - reporting period 2012; Denmark row, p. 1, Denmark.

[230] ECtHR, Violations by Article and State 2013 – reporting period 2013; Denmark row, p. 1, Denmark.

[231] ECtHR, Violations by Article and State 2014 – reporting period 2014; Denmark row, p. 1, Denmark.

[232] ECtHR, Violations by Article and State 2015 – reporting period 2015; Denmark row, p. 1, Denmark.

[233] ECtHR, Violations by Article and State 2016 – reporting period 2016; Denmark row, p. 1, Denmark.

[234] ECtHR, Violations by Article and State 2017 – reporting period 2017; Denmark row, p. 1, Denmark.

[235] ECtHR, Violations by Article and State 2018 - reporting period 2018; Denmark row, p. 1, Denmark.

[236] ECtHR, Violations by Article and State 2019 – reporting period 2019; Denmark row, p. 1, Denmark and footnote 3.

[237] ECtHR, Violations by Article and State 2020 - reporting period 2020; Denmark row, p. 1, Denmark.

[238] ECtHR, Violations by Article and State 2021 – reporting period 2021; Denmark row, p. 1, Denmark.

[239] ECtHR, Violations by Article and State 2022 - reporting period 2022; Denmark row, p. 1, Denmark.

[240] ECtHR, Violations by Article and State 2023 - reporting period 2023; Denmark row, p. 1, Denmark.

[241] ECtHR, Violations by Article and State 2024 – reporting period 2024; Denmark row, p. 1, Denmark.

[242] ECtHR, Violations by Article and State 2025 - reporting period 2025; Denmark row, p. 1, Denmark.

[243] ECtHR, Savran v. Denmark, Chamber, 57467/15, 1. October 2019 – reporting period 2019; judgment and outcome.

[244] ECtHR, Savran v. Denmark, Grand Chamber, 57467/15, 7. December 2021 – reporting period 2021; final Convention examination.

[245] ECtHR, HUDOC, decisions concerning Denmark – reporting period 2006–2025; Denmark; judgment years 2006–2025; final violation outcome; the same application number is deduplicated.

[246] UN OHCHR, Juris, six relevant treaty committees – reporting period 2006–2025; Denmark; decision years 2006–2025; favourable Views on the merits and protection findings; F.K. separately.

[247] ECtHR, Sørensen and Rasmussen v. Denmark (Grand Chamber), 52562/99, 52620/99 – reporting period: judgment 2006-01-11; final 2006-01-11; the judgment's §§ 75–77; particularly § 76 on the state's failure to protect and § 77 on the violation in respect of both applicants..

[248] Sørensen and Rasmussen v. Denmark (GC), 11.1.2006 – reporting period 2006-01-11; §§ 75–77; Public original judgment.

[249] ECtHR, Iversen v. Denmark, 5989/03 – reporting period judgment 2006-09-28; final 2006-12-28; The judgment's §§ 71–76: public expert bodies and delay in §§ 72–73, special diligence in § 74, total duration and Article 6 finding in §§ 75–76..

[250] Iversen v. Denmark, 28.9.2006 – reporting period 2006-09-28; §§ 71–76; Public original judgment.

[251] Jurica v. Croatia, 2.5.2017 – reporting period 2006-09-28; Reference to Iversen, paragraph 74, on special diligence in personal injury cases; Public original judgment.

[252] ECtHR, Hasslund v. Denmark, 36244/06 – reporting period judgment 2008-12-11; final 2009-03-11; The judgment's §§ 46–47; the Article 13 complaint in §§ 48–53 did not lead to a separate finding of violation..

[253] Hasslund v. Denmark, 11.12.2008 – reporting period 2008-12-11; §§ 46–47; §§ 48–53; publicly available original judgment.

[254] ECtHR, Moesgaard Petersen v. Denmark, 32848/06 – reporting period judgment 2008-12-11; final 2009-03-11; The judgment's §§ 48–49..

[255] Moesgaard Petersen v. Denmark, 11.12.2008 – reporting period 2008-12-11; §§ 48–49; Public original judgment.

[256] ECtHR, Christensen v. Denmark, 247/07 – reporting period judgment 2009-01-22; final 2009-04-22; The judgment's §§ 97–98 on duration and §§ 103–105 on remedies; findings of violation in §§ 98 and 105..

[257] Christensen v. Denmark, 22.1.2009 – reporting period 2009-01-22; §§ 97–98 and 103–105; Public original judgment.

[258] Committee of Ministers, CM/ResDH(2012)73: Christensen, Valentin and Nielsen – reporting period 2009-01-22; PDF p. 2: cases and violation findings; p. 3: Valentin, reference to the judgment's §§ 70–71; official execution resolution.

[258] Supplementary direct passage: Committee of Ministers, CM/ResDH(2012)73: Christensen, Valentin and Nielsen – reporting period 2009-03-26; PDF p. 2: cases and findings of violations; p. 3: Valentin, reference to judgment paragraphs 70–71; Official execution resolution.

[258] Supplementary direct passage: Committee of Ministers, CM/ResDH(2012)73: Christensen, Valentin and Nielsen – reporting period 2009-07-02; PDF p. 2: cases and findings of violations; p. 3: Valentin, reference to judgment paragraphs 70–71; Official execution resolution.

[259] ECtHR, Valentin v. Denmark, 26461/06 – reporting period judgment 2009-03-26; final 2009-06-26; The judgment's assessments under Article 6, Article 13 and P1-1 and operative provisions; §§ 70–71 on the prolonged burden on property are quoted in CM/ResDH(2012)73, PDF p. 3..

[260] ECtHR, Nielsen v. Denmark, 44034/07 – reporting period: judgment 2009-07-02; final 2009-10-02; the judgment's Article 6 assessment and operative provisions; officially reproduced in CM/ResDH(2012)73, PDF p. 2..

[261] ECtHR, Osman v. Denmark, 38058/09 – reporting period: judgment 2011-06-14; final 2011-09-14; The judgment's Article 8 assessment and operative provisions; official legal summary in Information Note 142, June 2011, Osman..

[262] ECtHR, Osman v. Denmark: legal summary – reporting period 2011-06-14; Article 8, finding of a violation; Official legal summary from the ECtHR.

[263] ECtHR, Biao v. Denmark (Grand Chamber), 38590/10 – reporting period: judgment 2016-05-24; final 2016-05-24; the Grand Chamber judgment's assessment under Article 14 taken together with Article 8; operative point 1 finds a violation, point 2 makes no separate examination under Article 8..

[263] Supplementary direct passage: Biao v. Denmark (GC), 24.5.2016 – reporting period 2016-05-24; operative provisions points 1–2; publicly available original judgment.

[264] ECtHR, Grand Chamber judgment Biao v. Denmark, 24.5.2016 – reporting period 2016-05-24; conclusion and reasoning concerning the 28-year rule; official judgment summary from the ECtHR Registry.

[265] ECtHR, Tim Henrik Bruun Hansen v. Denmark, 51072/15 – reporting period: judgment 2019-07-09; final 2019-10-09; Judgment paragraphs 65–84; in particular paragraphs 83–84..

[266] Tim Henrik Bruun Hansen v. Denmark, 9.7.2019 – reporting period 2019-07-09; §§ 65–84, particularly 83–84; publicly available original judgment.

[267] ECtHR, Aggerholm v. Denmark, 45439/18 – reporting period: judgment 2020-09-15; final 2020-12-15; the judgment's Article 3 assessment concerning continued restraint and operative provisions; official judgment press release 15.9.2020..

[268] ECtHR, M.A. v. Denmark (Grand Chamber), 6697/18 – reporting period: judgment 2021-07-09; final 2021-07-09; the Grand Chamber judgment's §§ 194–195: failure to strike a fair balance and the Article 8 finding; § 154 on international criticism in 2016 and 2017; operative point 2..

[268] Supplementary direct passage: M.A. v. Denmark (GC), 9.7.2021 – reporting period 2021-07-09; § 154; §§ 194–195; operative point 2; publicly available original judgment.

[269] ECtHR, Grand Chamber judgment M.A. v. Denmark, 9.7.2021 – reporting period 2021-07-09; Article 8 finding; official judgment summary from the ECtHR Registry.

[270] ECtHR, Abdi v. Denmark, 41643/19 – reporting period: judgment 2021-09-14; final 2022-01-17; the judgment's Article 8 assessment and operative provisions; §§ 39–42 are discussed in the later original Nguyen judgment..

[271] ECtHR, Judgments of 14 September 2021 – reporting period 2021-09-14; Abdi: Article 8 finding, permanent entry ban, arrival at the age of four; Official judgment summary by the ECtHR Registry.

[272] ECtHR, Grand Chamber Panel decisions, January 2022 – reporting period 2021-09-14; referral request rejected 17.1.2022; Abdi final; official ECtHR notice.

[273] Nguyen v. Denmark, 9.4.2024 – reporting period 2023-09-05; References to Noorzae, §§ 32–34; Public original judgment.

[273] Additional direct passage: Nguyen v. Denmark, 9.4.2024 – reporting period 2021-09-14; References to Abdi, §§ 39–42; Public original judgment.

[273] Supplementary direct passage: Nguyen v. Denmark, 9.4.2024 – reporting period 2023-09-05; references to Sharifi, §§ 33–35; publicly available original judgment.

[273] Supplementary direct passage: Nguyen v. Denmark, 9.4.2024 – reporting period 2024-04-09; paragraphs 29 and 35–39; operative provision 2; Public original judgment.

[274] ECtHR, Forthcoming judgments and decisions 14–16.9.2021 – reporting period 2021-09-14; Abdi: age on arrival and permanent entry ban; Official announcement of forthcoming judgment; used only for facts.

[275] ECtHR, Savran v. Denmark (Grand Chamber), 57467/15 – reporting period: judgment 2021-12-07; final 2021-12-07; The Grand Chamber judgment's Article 8 assessment, including paragraphs 193–194 on mental illness and the weight of the criminal-offending criterion, and operative provisions..

[276] ECtHR, Grand Chamber judgment Savran v. Denmark, 7.12.2021 – reporting period 2021-12-07; Article 8 violation; no Article 3 violation; official judgment summary from the ECtHR Registry.

[277] ECtHR, Annual Report 2021 – reporting period 2021-12-07; Savran: expulsion of a person with mental illness, Article 8; Official annual report.

[278] ECtHR, K.K. and Others v. Denmark, 25212/21 – reporting period: judgment 2022-12-06; final 2023-03-06; Judgment paragraphs 75–76; operative provision 4 on the children, provision 3 finding no violation for the intended mother..

[279] K.K. and Others v. Denmark, 6.12.2022 – reporting period 2022-12-06; §§ 75–76; operative provisions points 3–4; Public original judgment.

[280] ECtHR, Noorzae v. Denmark, 44810/20 – reporting period: judgment 2023-09-05; final 2023-12-05; The judgment's Article 8 assessment and operative provisions; official judgment summary 5.9.2023, PDF p. 2. Paragraphs 32–34 are discussed in Nguyen..

[281] ECtHR, Judgments of 5 September 2023 – reporting period 2023-09-05; PDF p. 2: Noorzae and Sharifi, both Article 8; official judgment summary from the ECtHR Registry.

[282] ECtHR, Sharifi v. Denmark, 31434/21 – reporting period: judgment 2023-09-05; final 2023-12-05; the judgment’s Article 8 assessment and operative provisions; official judgment summary 5.9.2023, PDF p. 2. §§ 33–35 are discussed in Nguyen..

[283] ECtHR, El-Asmar v. Denmark, 27753/19 – reporting period: judgment 2023-10-03; final 2024-01-03; The judgment's substantive and procedural Article 3 assessments and operative provisions; official judgment summary 3.10.2023, PDF pp. 3–4, Decision of the Court..

[284] ECtHR, Judgment El-Asmar v. Denmark, 3.10.2023 – reporting period 2023-10-03; PDF pp. 3–4: both Article 3 limbs; pp. 2–3: CPT’s criticisms in 2014 and 2019; Official judgment summary by the ECtHR Registry.

[285] ECtHR, Nguyen v. Denmark, 2116/21 – reporting period: judgment 2024-04-09; final 2024-07-09; the judgment’s §§ 29 and 35–39; operative point 2..

[286] ECtHR, Judgments of 9 April 2024 – reporting period 2024-04-09; PDF pp. 1–2: Nguyen and Sarac, both Article 8; official judgment summary from the ECtHR Registry.

[287] ECtHR, Sarac v. Denmark, 19866/21 – reporting period: judgment 2024-04-09; final 2024-07-09; The judgment's Article 8 assessment and operative provisions; official judgment summary 9.4.2024, PDF pp. 1–2..

[288] ECtHR, Daugaard Sørensen v. Denmark, 25650/22 – reporting period: judgment 2024-10-15; final 2025-01-15; the judgment's overall assessment under Article 3 and Article 8 and its operative provisions; official judgment press release 15.10.2024, conclusion and Decision of the Court..

[289] ECtHR, Judgment Daugaard Sorensen v. Denmark, 15.10.2024 – reporting period 2024-10-15; Conclusion; procedural failures; Articles 3 and 8; Official judgment summary from the Registry of the ECtHR.

[290] ECtHR, Sharafane v. Denmark, 5199/23 – reporting period judgment 2024-11-12; final 2025-03-17; The judgment's assessment under Article 8, including § 57 on the entry ban, and operative provisions. Official judgment summary 12.11.2024, PDF pp. 1–2, confirms the Article 8 finding..

[291] ECtHR, Judgments of 12 November 2024 – reporting period 2024-11-12; PDF pp. 1–2: Sharafane, Article 8 finding; official judgment summary from the ECtHR Registry.

[292] ECtHR, Grand Chamber Panel decisions, March 2025 – reporting period 2024-11-12; Sharafane: referral request rejected 17.3.2025; Official communication from the ECtHR.

[293] Allabed v. Denmark, 2026 – reporting period 2024-11-12; § 52 and the reference to Sharafane, § 57; used for the relationship between the reasoning, not for the numerical count; Public original judgment.

[294] ECtHR, Kalkan v. Denmark, 51781/22 – reporting period judgment 2025-05-27; final 2025-08-27; The judgment's assessment under Article 2 concerning instructions and training and operative provisions; official judgment summary 27.5.2025, PDF pp. 1–2..

[295] ECtHR, Judgments and decisions of 27 May 2025 – reporting period 2025-05-27; PDF p. 1: Kalkan, Article 2 finding; p. 2: compensation; Official judgment summary from the Registry of the ECtHR.

[296] ECtHR, Mortensen v. Denmark, 16756/24 – reporting period judgment 2025-10-21; final 2026-01-21; The judgment's §§ 38–40 on the debate and the High Court's assessment; point 2 of the operative provisions finds a violation of Article 10..

[297] Mortensen v. Denmark, 21.10.2025 – reporting period 2025-10-21; §§ 38–40; point 2 of the operative provisions; header FINAL 21/01/2026; Public original judgment.

[298] UN Committee on the Elimination of Racial Discrimination, Mohamed Hassan Gelle, CERD/C/68/D/34/2004 – reporting period adopted 2006-03-06; §8.

[299] UN Committee on the Elimination of Racial Discrimination, Murat Er, CERD/C/71/D/40/2007 – reporting period adopted 2007-08-08; §8; PDF p.10.

[300] UN Human Rights Committee, Mohamed El-Hichou, CCPR/C/99/D/1554/2007 – reporting period adopted 2010-07-22; §8.

[301] UN Committee on the Elimination of Racial Discrimination, Saada Mohamad Adan, CERD/C/77/D/43/2008 – reporting period adopted 2010-08-13; §8.

[302] UN Committee against Torture, Said Amini, CAT/C/45/D/339/2008 – reporting period: adopted 2010-11-15; §9.9.

[303] UN Committee on the Elimination of Racial Discrimination, Mahali Dawas and Yousef Shava, CERD/C/80/D/46/2009 – reporting period: adopted 2012-03-06; paragraph 8; PDF pp.11–12.

[304] UN Committee against Torture, K. H., CAT/C/49/D/464/2011 – reporting period adopted 2012-11-23; §9.

[305] UN Human Rights Committee, X, CCPR/C/110/D/2007/2010 – reporting period adopted 2014-03-26; §9.5.

[306] UN Human Rights Committee, Q, CCPR/C/113/D/2001/2010 – reporting period adopted 2015-04-01; §8.

[307] UN Human Rights Committee, A. H., CCPR/C/114/D/2370/2014 – reporting period adopted 2015-07-16; §9.

[308] UN Human Rights Committee, Warda Osman Jasin, CCPR/C/114/D/2360/2014 – reporting period adopted 2015-07-22; §9.

[309] UN Human Rights Committee, X, CCPR / C / 114 / D / 2389 / 2014 - reporting period adopted 2015-07-22; § 8.

[310] UN Human Rights Committee, Osayi Omo-Amenaghawon, CCPR/C/114/D/2288/2013 – reporting period adopted 2015-07-23; §8.

[311] UN Human Rights Committee, H. E. A. K., CCPR/C/114/D/2343/2014 – reporting period: adopted 2015-07-23; §9.

[312] UN Human Rights Committee, Jenirthan Rasappu and Jenarthan Rasappu, CCPR/C/115/D/2258/2013 – reporting period adopted 2015-11-04; §8.

[313] UN Committee on the Elimination of Discrimination against Women, A., CEDAW/C/62/D/53/2013 – reporting period adopted 2015-11-19; §11.

[314] UN Committee against Torture, F.K., CAT/C/56/D/580/2014 – reporting period adopted 2015-11-23; §8.

[315] UN Committee on the Elimination of Discrimination against Women, M. W., CEDAW/C/63/D/46/2012 – reporting period adopted 2016-02-22; §6.

[316] UN Human Rights Committee, Abdilafir Abubakar Ali and Mayul Ali Mohamad, CCPR/C/116/D/2409/2014 – reporting period adopted 2016-03-29; §8.

[317] UN Committee against Torture, J. N., CAT/C/57/D/628/2014 – reporting period adopted 2016-05-13; §8.

[318] UN Human Rights Committee, E. U. R., CCPR/C/117/D/2469/2014 – reporting period: adopted 2016-07-01; §10.

[319] UN Human Rights Committee, A. A. S., CCPR/C/117/D/2464/2014 – reporting period: adopted 2016-07-04; §8.

[320] UN Human Rights Committee, Ms. Obah Hussein Ahmed, CCPR/C/117/D/2379/2014 – reporting period adopted 2016-07-07; §14.

[321] UN Human Rights Committee, M. K. H., CCPR/C/117/D/2462/2014 - reporting period: adopted 2016-07-12; §9.

[322] UN Human Rights Committee, R. A. A. and Z. M., CCPR/C/118/D/2608/2015 – reporting period: adopted 2016-10-28; §8.

[323] UN Committee against Torture, M. B., A. B., D. M. B. and D. B., CAT/C/59/D/634/2014 – reporting period: adopted 2016-11-25; §10.

[324] UN Human Rights Committee, Raziyeh Rezaifar, CCPR/C/119/D/2512/2014 – reporting period adopted 2017-03-10; §10.

[325] UN Human Rights Committee, Y. A. A. and F. H. M., CCPR/C/119/D/2681/2015 – reporting period adopted 2017-03-10; §8.

[326] UN Human Rights Committee, F and G, CCPR/C/119/D/2530/2015 – reporting period adopted 2017-03-16; §9.

[327] UN Committee against Torture, A. M. D. et al., CAT/C/60/D/653/2015 – reporting period: adopted 2017-05-12; §10.

[328] UN Human Rights Committee, M. S. aka M. H. H. A. D., CCPR/C/120/D/2601/2015 – reporting period: adopted 2017-07-27; §10.

[329] UN Human Rights Committee, Hibaq Said Hashi, CCPR/C/120/D/2470/2014 – reporting period adopted 2017-07-28; §10.

[330] UN Committee against Torture, G. I., CAT/C/61/D/625/2014 – reporting period adopted 2017-08-10; §9.

[331] UN Human Rights Committee, O. A., CCPR/C/121/D/2770/2016 – reporting period adopted 2017-11-07; §9.

[332] UN Committee on the Rights of the Child, I. A. M., CRC/C/77/D/3/2016 – reporting period: adopted 2018-01-25; §11.10.

[333] UN Human Rights Committee, C. L. and Z. L., CCPR/C/122/D/2753/2016 – reporting period adopted 2018-03-26; §9.

[334] UN Human Rights Committee, Bayush Alemseged Araya, CCPR/C/123/D/2575/2015 – reporting period adopted 2018-07-13; §10.

[335] UN Human Rights Committee, K. H., CCPR/C/123/D/2423/2014 – reporting period: adopted 2018-07-16; §9.

[336] UN Committee on the Rights of Persons with Disabilities, Iuliia Domina and Max Bendtsen, CRPD/C/20/D/39/2017 – reporting period: adopted 2018-08-31; §9.

[337] UN Committee on the Elimination of Racial Discrimination, S. A., CERD/C/97/D/58/2016 – reporting period adopted 2018-12-13; §8.

[338] UN Human Rights Committee, A. B. H., CCPR/C/126/D/2603/2015 – reporting period adopted 2019-07-08; §10.

[339] UN Committee on the Elimination of Discrimination against Women, R. S. A. A. et al, CEDAW/C/73/D/86/2015 – reporting period: adopted 2019-07-15; §9.

[340] UN Human Rights Committee, R. M. and F. M., CCPR/C/126/D/2685/2015 - reporting period: adopted 2019-07-24; §10.

[341] UN Human Rights Committee, Nimo Mohamed Aden and Liban Muhammed Hassan, CCPR/C/126/D/2531/2015 – reporting period adopted 2019-07-25; §11.

[342] UN Committee on the Rights of the Child, W. M. C., CRC/C/85/D/31/2017 – reporting period adopted 2020-09-28; §9.

[343] UN Committee on the Rights of the Child, R. H. M., CRC/C/86/D/83/2019 – reporting period: adopted 2021-02-04; §8.9.

[344] UN Human Rights Committee, A. M. F. and A. M., CCPR/C/132/D/2651/2015 – reporting period: adopted 2021-07-22; §11.

[345] UN Human Rights Committee, M. N., CCPR/C/132/D/3188/2018 - reporting period: adopted 2021-07-22; §8.

[346] UN Committee on the Rights of the Child, S. S. F., CRC/C/90/D/96/2019 – reporting period adopted 2022-05-27; §8.9.

[347] UN Committee on the Rights of the Child, H. K., CRC/C/90/D/99/2019 – reporting period adopted 2022-06-01; §8.

[348] UN Human Rights Committee, J. S. K. N., CCPR/C/136/D/2754/2016 - reporting period: adopted 2022-10-25; §9.

[349] UN Committee on the Elimination of Racial Discrimination, Momodou Jallow, CERD/C/108/D/62/2018 – reporting period adopted 2022-12-01; §8.

[350] UN Human Rights Committee, Elezjana Elezaj, CCPR/C/137/D/2858/2016 - reporting period: adopted 2023-03-16; §9.

[351] UN Committee on the Rights of the Child, F. M. A. and H. K. A., CRC/C/93/D/140/2021 – reporting period adopted 2023-05-16; §7.9.

[352] UN Committee on the Rights of Persons with Disabilities, Søren Mikkelsen, CRPD/C/29/D/61/2019 – reporting period adopted 2023-08-25; §10.

[353] UN Committee on the Rights of the Child, O. M., CRC/C/94/D/145/2021 – reporting period: adopted 2023-09-19; §8.8.

[354] UN Committee on the Rights of the Child, H. H., CRC/C/96/D/169/2021 – reporting period adopted 2024-05-24; §8.8.

[355] UN Committee against Torture, F.K., CAT/C/70/D/743/2016 – reporting period 2020-12-30; paragraph 8.2 (finding of a serious Article 22 violation); paragraph 10(a) (substantive complaint rejected under Article 22(2)).

[356] UN Committee on the Rights of Persons with Disabilities, follow-up report CRPD/C/32/3 – reporting period: published 2025-05-05; section II.G, §§41–46; follow-up decision §46.

[357] Refugee Appeals Board, annual report 2006 - reporting period 2006;), p. 196.

[358] Refugee Appeals Board, annual report 2007 – reporting period 2007;), p. 228.

[359] Refugee Appeals Board, annual report 2008 – reporting period 2008;), p. 249.

[360] Refugee Appeals Board, annual report 2009 – reporting period 2009;), p. 296.

[360] Supplementary direct passage: Flygtningenævnet, annual report 2009 – reporting period 2009;), p. 298.

[361] Refugee Appeals Board, annual report 2010 – reporting period 2010;), p. 367.

[361] Supplementary direct passage: Flygtningenævnet, annual report 2010 – reporting period 2010;), p. 369.

[362] Refugee Appeals Board, annual report 2011 – reporting period 2011;), p. 312.

[363] Refugee Appeals Board, annual report 2012 - reporting period 2012;), p. 361.

[363] Supplementary direct passage: Refugee Appeals Board, annual report 2012 – reporting period 2012;), p. 363.

[364] Refugee Appeals Board, annual report 2013 - reporting period 2013;), p. 456.

[364] Additional direct passage: Refugee Appeals Board, annual report 2013 – reporting period 2013;), p. 457.

[365] Flygtningenævnet, annual review 2014 – reporting period 2014;), p. 479.

[365] Supplementary direct passage: Refugee Appeals Board, annual report 2014 – reporting period 2014;), p. 480.

[366] Refugee Appeals Board, annual report 2015 – reporting period 2015;), p. 554.

[366] Supplementary direct passage: Flygtningenævnet, annual report 2015 – reporting period 2015;), p. 555.

[367] Refugee Appeals Board, annual report 2021 - reporting period 2021;), p. 558.

[367] Additional direct passage: Refugee Appeals Board, annual report 2021 – reporting period 2021;), p. 559.

[368] The Refugee Board, Annual Report 2022 - review period 2022;), p. 592.

[369] Refugee Appeals Board, annual report 2023 - reporting period 2023;), p. 540.

[370] Refugee Appeals Board, annual report 2024 – reporting period 2024;), p. 512.

[371] Refugee Appeals Board, annual report 2025 – reporting period 2025;), p. 534.

[372] Patientforsikringen, analysis of 2006–2011 (9. March 2012) – reporting period 2006; p. 13, table 3; 2011 provisional.

[372] Additional direct passage: Patient Insurance Association, analysis of 2006–2011 (9. March 2012) – reporting period 2007; p. 13, table 3; 2011 provisional.

[372] Additional direct passage: Patient Insurance Association, analysis of 2006–2011 (9. March 2012) – reporting period 2008; p. 13, table 3; 2011 provisional.

[372] Additional direct passage: Patient Insurance Association, analysis of 2006–2011 (9. March 2012) – reporting period 2009; p. 13, table 3; 2011 provisional.

[372] Supplementary direct passage: Patientforsikringen, analysis of 2006–2011 (9. March 2012) – reporting period 2010; p. 13, Table 3; 2011 provisional.

[372] Supplementary direct passage: Patientforsikringen, analysis of 2006–2011 (9. March 2012) – reporting period 2011; p. 13, table 3; 2011 provisional.

[373] Tilma et al. (2015), The Danish Patient Compensation Association database – reporting period 2012; DPCA database, figures 1-2.

[374] Patient Compensation, Treatment injuries 2017 – reporting period 2013; table 3-4, p. 13-18.

[374] Supplementary direct passage: Patienterstatningen, Treatment injuries 2017 – reporting period 2014; tables 3-4, pp. 13-18.

[374] Supplementary direct passage: Patienterstatningen, Treatment Injuries 2017 – reporting period 2015; tables 3-4, pp. 13-18.

[374] Supplementary direct passage: Patienterstatningen, Treatment Injuries 2017 – reporting period 2016; tables 3-4, pp. 13-18.

[375] Patienterstatningen, Treatment Injuries 2021, 27. June 2022 – reporting period 2017; tables 3-4, pp. 3-8.

[375] Supplementary direct passage: Patienterstatningen, Treatment Injuries 2021, 27. June 2022 – reporting period 2018; tables 3-4, pp. 3-8.

[375] Supplementary direct passage: Patienterstatningen, Treatment Injuries 2021, 27. June 2022 – reporting period 2019; tables 3-4, pp. 3-8.

[375] Additional direct passage: Patient Compensation Association, Treatment injuries 2021, 27. June 2022 – reporting period 2020; table 3-4, p. 3-8.

[376] Ankestyrelsen, Child Case Barometer 2020 – reporting period 2020; printed p. 18; 25.03.2016–25.03.2019.

[376] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2020 – reporting period 2020; Printed p. 20; 25.03.2016–25.03.2019.

[376] Additional direct passage: Appeals Board, Child Welfare Case Barometer 2020 – reporting period 2020; Printed p. 28; 25.03.2016–25.03.2019.

[376] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2020 – reporting period 2020; printed p. 30; 25.03.2016–25.03.2019.

[376] Supplementary direct passage: Ankestyrelsen, Child Case Barometer 2020 – reporting period 2020; printed p. 34; 25.03.2016–25.03.2019.

[377] Ankestyrelsen, Child Case Barometer, pilot 2019 – reporting period 07.11.2015–07.11.2018; printed pp. 25–26; 12 municipalities.

[378] Ankestyrelsen, Disability pension without referral to the rehabilitation team (2019), original methodology – reporting period: decisions not before 01.10.2017; latest cases. No common latest decision date is published in the methodology annex examined.; Separate annex report, physical PDF pp. 5–8, especially pp. 5–6..

[379] Ankestyrelsen, Use of force against people with dementia (2015), original methodology – reporting period most recent decisions before 31.12.2014, then working backwards; no common earliest decision date specified in the request.; methodology physical PDF pp. 116–117; request letter physical PDF p. 149..

[380] Ankestyrelsen, Sickness Benefits Act § 7 (2016), original methodology – reporting period: first 12 municipalities: the most recent ten decisions before 01.07.2015, requested on 11.08.2015. Four additional municipalities: request letter 16.09.2015; at the end of September, decisions made after 30.06.2015 but before the request were also accepted. No common earliest decision date published.; methodology printed pp. 69–70, physical PDF pp. 72–73; supplementary request letter dated 16.09.2015, printed p. 113/physical PDF 116; the letter’s population on printed p. 115/physical PDF 118..

[380] Supplementary direct passage: Ankestyrelsen / Borgerrådgiveren, Sickness Benefits Act § 7 (2016) – reporting period: first 12 municipalities: most recent ten decisions before 01.07.2015, requested on 11.08.2015. Four additional

municipalities: request letter 16.09.2015; at the end of September, decisions after 30.06.2015 but before the request were also accepted. No common earliest decision date published.; printed pp. 29–30.

[381] Appeals Board / Citizens' Adviser, Practice survey of sanctions for failure to attend an employment programme or interview (2024) – reporting period 01.06.2022–15.04.2023.; Table 2.1.

[382] Ankestyrelsen, Practice study of sanctions for failure to attend a programme or interview (2024), original methodology – reporting period 01.06.2022–15.04.2023.; Current accessible original: physical/printed PDF p. 6 on the period and p. 14, Table 2.1 on outcomes. The PDF has 54 pages; the older contents list does not correctly reflect all new page numbers..

[383] Ankestyrelsen, Ankestyrelsen's statement on the handling of appeals from Seniorpensionsenheden 2024 – reporting period: decision year 2024; p. 6.

[384] Act no. 557 of 27. May 2025 on public employees' freedom of expression – §§ 1-4.

[385] Act no. 1436 of 29. June 2021 on the protection of whistleblowers – §§ 1, 5-8 and 28-29.

[386] UN Convention on the Rights of Persons with Disabilities, Executive Order no. 35 of 15. September 2009 – Article 23, paragraphs 2-4, printed pp. 22-23, PDF pp. 23-24.

[386] Supplementary direct passage: UN Convention on the Rights of Persons with Disabilities, Executive Order no. 35 of 15. September 2009 – Articles 4-5, 7, 13-16, 19, 23 and 25; original Danish and English treaty text.

[387] ECtHR, Guide on Article 2, updated 28. February 2026 – sections 23-25 on the Osman and Kurt tests; physical PDF pp. 10-11.

[388] ECtHR, Guide on Article 3, updated 31. August 2026 – sections 112-121, 139-143 and 150-157; physical PDF pp. 27-28 and 32-36; O'Keeffe, Gäfgen and other named case law.

[389] ECtHR, Guide on Article 8, updated 28. February 2026 – paragraphs 422-431 on placement, procedure and reunification; physical PDF pp. 109-110.

[390] UN Convention on the Rights of the Child (1989), original treaty text in UNICEF, For every child every right (2019), treaty annex – Article 3, 9, 12, 18-19, 24-25, 37 and 39; physical PDF p. 64-70.

[391] UN OHCHR, International Covenant on Civil and Political Rights (1966) – original treaty text, Articles 2, 6-7, 9, 17, 23-24 and 26.

[392] UN Convention against Torture (1984), original treaty text in OHCHR Cambodia, Convention against Torture and its Optional Protocol – Articles 1-2 and 10-16; physical PDF pp. 6-11.

[393] High Court of Western Denmark, Judgment of 15. October 2020, S-0338-20, AM 2020.10.15V2 – judgments and administrative originals, PDF pp. 1-7 and 19-21.

Ole Bakkestrøm

Project Manager, Projekt Paulus

11. October 2026

Ex officio et ex conscientia.