



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

FOURTH SECTION

CASE OF RASMUSSEN AND OTHERS v. DENMARK

(Application no. 2390/24)

JUDGMENT

Art 2 (substantive) • Life • Positive obligations • Accidental death of a prisoner caused by a drug overdose • Domestic courts thoroughly examined the case in the light of the Court's case-law • In case-circumstances not established that the prison authorities knew or ought to have known there was a real and immediate risk to his life • Prison authorities took basic precautions to minimise any potential risk to protect the prisoner's health and well-being

Prepared by the Registry. Does not bind the Court.

STRASBOURG

25 November 2025

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

In the case of Rasmussen and Others v. Denmark,

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

Lado Chanturia, *President*,

Jolien Schukking,

Lorraine Schembri Orland,

Anja Seibert-Fohr,

Anne Louise Bormann,

Sebastian Rădulețu,

András Jakab, *judges*,

and Simon Petrovski, *Deputy Section Registrar*,

Having regard to:

the application (no. 2390/24) against the Kingdom of Denmark lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms (“the Convention”) by three Danish nationals, whose personal details are set out in the appendix to this judgment;

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

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

Having deliberated in private on 30 September and 4 November 2025,

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

INTRODUCTION

1. The present case concerns the accidental death of a prisoner caused by an overdose. His relatives, the applicants, complained that the respondent State had not discharged its obligations under Articles 2 and 3 of the Convention.

THE FACTS

2. The applicants are the mother, wife and child of J.F., who died on 17 November 2017. They were represented by Mr Tobias Stardarfeld Jensen, a lawyer practising in Aarhus.

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

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

I. INCIDENT ON 16 AND 17 NOVEMBER 2017 GIVING RISE TO THE APPLICANTS' COMPLAINT UNDER THE CONVENTION

5. On 22 September 2017, J.F., who was serving a prison sentence and known to be addicted to benzodiazepines and other substances, was transferred to Kragsskovhede Prison.

6. On the morning of 16 November 2017 J.F. was seen by the prison nurse and started a course of antibiotics for a dental abscess.

7. On the same day, around 7.40 p.m., prison officer L.R. observed that J.F. appeared intoxicated. A fellow inmate, M.V.T., alleged that J.F. had stolen a bottle of methadone tablets when he had seen the nurse earlier that day and that he had taken too many of those tablets. The prison officer contacted the nurse several times. They agreed that J.F. should be transferred to the prison's medical unit for observation, and that a doctor or the emergency services should be called if J.F.'s condition deteriorated. At the medical unit, prison officers M.B. and J.P. talked to J.F., who denied taking anything other than antibiotics. At around 8.15 p.m. M.B. and J.F. went outside to smoke, and subsequently went to the library to get some books for J.F. Thereafter he went to bed in a provisional observation cell (the disciplinary cell close to the staff office). Meanwhile, at 8.45 p.m. J.F.'s actual cell was searched. A piece of cardboard was found with two lines of powder arranged on it. At around 9.20 p.m. prison officer L.R. went to give a duvet to J.F., who was already asleep. The prison officer on the night shift, P.M., observed J.F. hourly without entering the cell; it appears that the checks occurred at least at 11 and 11.55 p.m. At all times J.F. was snoring or moving. For further details, see the evidence given during the civil proceedings described below.

8. On 17 November 2017 at 12.15 a.m. prison officer P.M. noticed that J.F. was no longer moving. The prison staff gave him first aid and called an ambulance. J.F. was declared dead at 1.10 a.m.

9. At the time of the events, Kragsskovhede Prison was organisationally placed under the Regional Office of the Prison and Probation Service in Central and Northern Jutland (*Kriminalforsorgsområdet Midt- og Nordjylland*, henceforth "the Prison and Probation Service"), which initiated an investigation.

10. The dispensary at Kragsskovhede Prison was fitted with locked cabinets for dangerous medicines behind the counter on the staff side. From a case summary of 17 November 2017 prepared by the Prison and Probation Service it follows that the prison nurse had confirmed in a telephone call on 16 November 2017 at 8.30 p.m. to L.R. that the prison did indeed keep bottles of 100 methadone tablets. The following day, the nurse had discovered that a bottle of those tablets could possibly have gone missing on the morning of 16 November 2017, when a colleague had left for a few seconds to get a sticky note. However, it could not be definitively confirmed or disproved.

11. On 21 November 2017 an autopsy was performed on J.F.'s body. The following appears in the forensic toxicology report of 11 January 2018:

“Toxicological findings

Conclusion

The opioids methadone, oxycodone and fentanyl were detected in concentrations that may, depending on tolerance level, be consistent with a severe or lethal poisoning.

A number of benzodiazepines were detected in concentrations that may enhance the severity of an opioid poisoning.

...

Methadone was detected in a concentration seen both when used for treatment and in connection with poisoning symptoms or lethal poisoning. Methadone is used, among other things, for pain relief and for opioid substitution treatment; brand name: Methadone.

...

Methadone, fentanyl and oxycodone are all opioids and were detected in concentrations that can be seen, when combined, in connection with treatment or severe or lethal poisoning. The symptoms of poisoning are impaired consciousness, shortness of breath and, as far as methadone is concerned, cardiac arrhythmia. Persons taking opioids daily acquire tolerance, and therefore the risk of poisoning is highly individual. In the relevant case, the deceased was not treated with opioids on a regular basis.”

12. A supplementary autopsy report of 15 January 2018 stated that, based on the forensic toxicology report, the information on file and the post-mortem findings, it must be assumed that the cause of the death was poisoning caused by methadone, oxycodone, fentanyl and benzodiazepines.

13. An investigation was initiated by the police to ascertain whether the conditions had been met for bringing criminal charges against the prison officers involved. After questioning the persons involved, at some unknown date, the police decided to discontinue the investigation as it could not reasonably be determined that a criminal offence had been committed.

14. A report was filed with the Danish Patient Safety Authority (*Styrelsen for Patientsikkerhed*) regarding Kragshovede Prison. After an inspection on 3 September 2019, the authority classified the prison as having “major problems of significance to patient safety”. Consequently, on 12 December 2019, the authority issued an enforcement notice requiring the prison to comply with the rules governing the storage of medicines and to ensure the safe administration of medication.

II. EXAMINATION OF THE CASE BY THE OMBUDSMAN

15. On 17 January 2020 the Prison and Probation Service sent an overall assessment of the course of events to the Parliamentary Ombudsman. It noted that Kragshovede Prison had not meticulously followed Instruction no. 104 of 21 July 2014 on dealing with an intoxicated client (see paragraph 43

below), in particular the nurse had not contacted a doctor and she had not arranged for J.F. to be observed at set times. The Prison and Probation Service also expressed criticism of the following aspects: there was no stock management or monitoring of the stock of medicines in the prison (which could have helped clarify whether anything had been missing); J.F. had not been formally searched when he had arrived at the medical unit; the substance discovered in J.F.'s cell had been destroyed and therefore could not be analysed; and J.F. had not been asked to provide a urine sample.

16. On 20 March 2020 the Parliamentary Ombudsman made his assessment of the case (and nine other cases concerning suicide attempts in the prison). He noted the criticisms already raised by the Prison and Probation Service and found no reason to take further action.

17. Subsequently, Kragsskovhede Prison tightened the procedures for entry into the dispensary, refurbishing it and introducing a new stock management procedure for medicines.

III. CIVIL COMPENSATION PROCEEDINGS

18. On 16 November 2020 the applicants lodged claims for compensation against the prison authorities, contending that the authorities had failed to provide J.F. with adequate supervision and medical care and, accordingly, to protect his life.

19. Before the District Court (*Retten i Aalborg*) four witnesses were examined, including J.F.'s mother and wife, who provided testimony regarding J.F., their personal relationships and financial matters.

20. Prison officer M.B., who on the day in question had been working in the medical unit, explained to the District Court, *inter alia*, that J.F. had appeared intoxicated when he had arrived at the medical unit. M.B. did not know whether J.F.'s intoxication had been caused by tablets or drugs. J.F. had always appeared intoxicated, but it might also just have been his way of behaving. His assessment was based on J.F.'s behaviour, J.F.'s being able to find books and walk without staggering and the fact that nothing had changed in his level of intoxication as compared to earlier that day. It had been M.B.'s assessment that J.F. had been intoxicated because he had been squinting and had talked more slowly and partly with a nasal twang, but he could walk without staggering. It could have been a dose of strong medicine, or he could have taken something else. J.F. had not been severely intoxicated and he had not been unpleasant. He stated that in the medical unit of Kragsskovhede Prison, they admitted inmates for observation when they had to assess whether an inmate could stay or would have to be transferred to Aalborg Local Prison, where they had proper observation cells. The observation cell in Aalborg was used when an inmate was heavily drunk or intoxicated, or when there was a doubt as to an inmate's condition. In the cell in which J.F. had been placed, it was possible for staff to enter the cell at night in order to

check on the inmate. If M.B. had considered J.F.'s life to be in danger, he would have called 112 (the emergency services). They had checked on J.F. once every hour to see whether his level of intoxication had been increasing or decreasing. The next morning, a nurse would have attended to him.

Earlier that day, M.B. had met with a childhood friend whom J.F. had also known. All three of them had talked together. J.F.'s behaviour at that point had been almost like his behaviour that evening.

At around 8.30 p.m., M.B. had seen J.F. in the medical unit. L.R. and a colleague had gone to the dispensary, and he had looked after J.F. He had wanted to evaluate the visual observations that he had received from L.R. He had therefore taken J.F. outside to smoke and subsequently they had gone to the library. J.F. had been able to light a cigarette and open doors, bend down and find books. In doing so, M.B. had been able to gather a different impression of him than if they had just talked.

M.B. had perceived J.F. as high on medicine, which he had always been. He did not know J.F.'s urinary statistics. The library was a small room with a low bookcase. J.F. had squatted in there and had easily found three books, and they had then walked back to J.F.'s cell. He had told him that he would not be punished if he had taken something.

He had asked him many times whether he was sure that he had not taken anything. It had come as a shock to him that J.F. had subsequently died.

He had asked in more detail about the bottle of tablets. He had known that no bottles of tablets could have disappeared as he had been the one in charge of dispensing medicines all day. He had asked him anyway. J.F. had replied that he had not taken anything. His focus had been on whether J.F. had taken something that could have endangered his life.

When J.F. had been placed in his cell, M.B. had most likely "patted his pockets", which had not counted as a search. If it had been a search, two prison officers would have removed all the inmate's clothes and examined his body. He had been more interested in J.F.'s well-being and willingness to admit if he had taken anything. It had been his assessment that J.F. would have been less inclined to talk to him if he had been searched.

M.B. had not observed any changes in J.F.'s level of intoxication. J.F. had been very accommodating and talkative. M.B. had called the nurse and told her about his visual observations. He did not recall what she had said in return. So, he had done his best. His plan had been to wait and see whether things worsened. If he had considered it necessary to contact a doctor, he would have done so. It would have been necessary if he had had an indication that something was wrong. In that case he would always call for a doctor. He had not. Otherwise, he had had no knowledge of J.F.'s state of health. He had not been worse than others, he had not coughed or gasped for breath.

He had handed over his shift to the night shift officer. They had talked about the suspicions concerning the bottle of tablets and his discussion with the nurse. They had kept a sheet of the hourly observations. It had been their

assessment that it would have been possible for J.F. to return to his own cell, but they had chosen to keep him in the medical unit in order to keep an eye on him and to allow for a nurse to attend to him the next morning.

He did not recall at what point during the course of the events he had heard about the bottle of tablets. He recalled having been informed that a fellow inmate had said something about it.

21. M.V.T., a fellow inmate at the time, told the District Court, among other things, that he had been an inmate at Kragsskovhede Prison in November 2017 and that he had known J.F. On 16 November 2017 he had met J.F. in the smoking area at around 9.30 a.m. after J.F. had seen the nurse. J.F. had told him that the nurse's phone had rung and J.F. had therefore been alone in the dispensary. J.F. had found a bottle of tablets, which he had shown to M.V.T. It had been a bottle of 100 methadone tablets. There had been a label on it, and it had been prescribed for Kragsskovhede State Prison. He had noticed the label because that had been the former name of the prison. He had been shocked, and he had asked J.F. to hide the bottle. He had thought that the prison staff would turn the whole prison upside down when they realised that a bottle of tablets had gone missing. J.F. had promised to hide it. J.F. had been slightly intoxicated at that point. Normally, J.F. had been under the influence of medicine or cannabis most of the time. M.V.T. had seen J.F. several times that day, and every time J.F. had been waddling even more. At some point, J.F. had said to him that it had gone completely wrong because he had taken too many tablets.

Towards the evening, the situation had become even worse, and he had been sincerely concerned about J.F., who had been unable to walk and speak, and it had been difficult to talk to him. He had walked around like a lifeless body and had also fallen. At one point, M.V.T. had thought that things had gone really wrong. J.F. had tumbled forwards, hitting his head on a coffee cup without noticing. M.V.T. had been unable to talk to him. He had therefore gone to the office and talked to prison officer L.R. He had told L.R. that J.F. had shown him a bottle of methadone tablets. Although L.R. had appeared sceptical he had then called the nurse. She had said that it could not be true because they did not keep bottles of methadone in the prison.

He had then found J.F. in another cell that he had strayed into. It had not been possible to talk to J.F. M.V.T. had talked to L.R. again and had said that things had gone really wrong with J.F. and that they would have to call an ambulance. L.R. had asked him whether he was sure that what he had told him was correct. He had replied "yes". He had said that the bottle of tablets had had a prescription label saying "Kragsskovhede State Prison" and that he was therefore completely sure. Once more, L.R. had called the nurse, who had been more hesitant that time. They had not known whether a bottle of methadone had gone missing. M.V.T. had overheard that conversation between L.R. and the nurse. The message given by the nurse had been that J.F. had needed to be placed in the observation cell and be attended to once

every hour. L.R. had accompanied him to the cell where J.F. had been asleep sitting up. L.R. had accompanied J.F. to the medical unit, and after that he had not seen J.F. again.

22. By a judgment of 25 May 2022 the District Court found in favour of the applicants. Based on the autopsy report, viewed in conjunction with the testimony of M.V.T., the District Court found it established that J.F. had come into possession of a significant quantity of methadone originating from the prison on the morning of 16 November 2017, that he had taken a large quantity of that substance during the day, and that he had died from poisoning by methadone and other substances. The District Court found that it ought to have been clear to the prison staff that there had been a significant risk that J.F. had taken an overdose of methadone. In those circumstances, and because a doctor had not been called to attend to J.F., the prison staff had not acted as could reasonably be expected in the given situation, and thus had not met the obligation incumbent on the Prison and Probation Service to protect J.F.'s life. When awarding damages for non-pecuniary damage, however, the District Court took into account that "J.F. showed great contributory negligence by taking the tablets that he had come into possession of and that nothing indicates that he intended to harm himself." Against that background, each applicant was awarded 150,000 Danish kroner (DKK), equal to approximately 20,000 euros (EUR).

23. An appeal was lodged against that judgment with the High Court of Western Denmark (*Vestre Landsret*), before which J.F.'s mother and wife, and M.B. gave supplementary testimony. Moreover, prison officers L.R, P.M. and J.P. were examined.

24. Prison officer M.B. told the court that many of the inmates at the Kragshovede Prison were medicated and were substance abusers, walking around with glassy eyes and snuffling. When J.F. had been transferred to the prison's medical unit, he had given the same impression as other inmates who were substance abusers. It was sad, but he had never seen J.F. in a different state. He believed that he knew the inmates well enough to be able to tell whether an inmate's level of intoxication was more severe than usual. On that basis, it was his assessment that it could not be true that J.F. had taken as many tablets as M.V.T. had said. When L.R. had taken J.F. to the medical unit, M.B. had been instructed to assess the extent to which J.F. had been intoxicated. At first, he had not been informed that J.F. might have taken methadone. Based on his conversations with J.F. and the things he had witnessed, he had made the assessment that it had not been necessary to place J.F. in a cell in the medical unit; however, J.F. had been placed there as a precaution. M.B. had not been able to force J.F. to submit to urine testing. Had J.F. asked him to see a doctor, he would have arranged for that immediately. He had asked J.F. multiple times whether he had wanted to see a doctor, but J.F. had declined.

25. Prison officer L.R. told the court that he had been a prison officer at Kragsskovhede Prison for 12 years. His familiarity with J.F. had been limited, but J.F. had served time in the prison before. He had been one of those inmates who kept to themselves, but also an inmate who would often appear unwell or intoxicated. He had not been very energetic. On 16 November 2017, he had met J.F. at around 2 p.m., and he believed that he had also seen him at the roll calls at 3 p.m. and 5 p.m. On those occasions, he had noticed nothing unusual about J.F. Sitting in his office at around 7:30 p.m., he had seen J.F. staggering when entering another inmate's cell. M.V.T. had entered the office about 10 minutes later to inform him that J.F. had said that he had stolen a bottle of methadone from the nurse. L.R. had subsequently found J.F. asleep, and it had been necessary to shake him a bit to wake him up. That had indicated to him that J.F. had been under the influence of something. J.F. had appeared severely intoxicated. At first, the witness had taken M.V.T.'s information with a pinch of salt because M.V.T. was someone who often came by the office providing various pieces of information. However, L.R. had decided that they had to check whether M.V.T.'s information had been correct. He had therefore decided to place J.F. in the prison's medical unit. There, he had confronted J.F. with the fact that he appeared severely intoxicated, and he had asked J.F. whether he had taken "anything". J.F. had not mentioned stealing methadone but had said that the nurse had given him some medicine for a dental abscess, and that that was the reason why he appeared unwell. L.R. had then contacted the prison nurse, who had confirmed what J.F. had said about the medicine. The nurse had told L.R. that it was necessary to keep J.F. under observation, but had not specified how often they should carry out visual observations. As far as he recalled, he and his colleagues had discussed checking on J.F. at 30-minute or hourly intervals. They had not conducted an actual search prior to J.F.'s placement in the cell in the medical unit, but, considering the circumstances, he was of the opinion that they had been sufficiently thorough when checking J.F.'s clothes. He had been in the medical unit when the night shift had begun. His colleague P.M. had taken charge of the visual observations of J.F., including checking whether his condition deteriorated. As J.F. had denied taking anything, L.R. had not asked him whether he had wanted to see a doctor. If J.F. had asked to see a doctor, they would have contacted an on-call doctor. He had taken part in the search of J.F.'s cell on 16 November 2017. He did not recall whether the two prepared lines had been found in the fridge of the cell. At the prison, they had some tests that could be used to analyse the substance in question, including whether it had been methadone.

26. Prison officer, P.M., stated that she had started working at Kragsskovhede Prison 18 years ago. At the time, J.F. had been placed in the prison as a "vulnerable inmate", which was a category used for inmates in need of special attention. He had been what they called a "repeat inmate" as he had served multiple sentences in Kragsskovhede Prison. He had been a

quiet and calm person but had struggled with severe substance abuse. He had been intoxicated multiple times each week, and leading up to his death he had often been severely intoxicated. Previously, when unable to get his way, he had sometimes become very sad and had threatened to commit suicide. She believed that the fact that he had found a wife and fathered a daughter had changed his attitude and had made him more positive. He had not threatened to commit suicide in his last period of incarceration. It was correct that he had admitted to her multiple times that he had taken tablets and other drugs. The fact that some inmates confided in members of staff was probably because they knew that the staff cared about them. Inmates were punished if it was ascertained that they had used drugs. The punishment could be in the form of a “ban on leave of absence” meaning that the relevant inmate would be denied leave. If she asked inmates whether they had taken drugs or tablets, they normally answered truthfully if they could tell that she was asking because she cared. On 16 November 2017 she had seen J.F., as he had needed a duvet while staying in the medical unit. J.F. had not been formally placed in an observation cell, but he had been under observation in a cell located a few metres away from the staff office. Her colleague, M.B., had told her that J.F.’s intoxication had been wearing off. She would have called a doctor if it had been getting worse. Her colleague, L.R., had said to her that they had to pay attention to J.F. They had checked on him on a 30-minute or hourly basis. Just before midnight, she had observed J.F. moving as she had seen him move his arm. Around midnight, she had escorted another inmate to the toilet and had subsequently observed that J.F. had not been moving despite her knocking on his door.

27. Prison officer J.P. stated that in 2017, she had been a prison officer in the medical unit of Kragshovede Prison. J.F. had been a frequent inmate in the prison, and she felt that she had known him really well. He had been nice, but he had also struggled with substance abuse. Many of the inmates were addicts. When intoxicated, he had snuffled, and it had been difficult to make eye contact with him. He had been intoxicated on an almost daily basis. In the period leading up to his death, he had seemed joyful and his usual self. On 16 November 2017, she had worked a shift in the medical unit with her colleague, M.B. At around 8:15 p.m. her colleague, L.R., had called to inform them that it was suspected that J.F. had taken some tablets. When J.F. had arrived at the medical unit, she and M.B. had talked to him. She had noticed that J.F. had been high. She and M.B. had asked J.F. whether he had taken anything that his body could not tolerate. He had insisted that he had not taken anything, which they had believed. Her colleague had then gone outside to smoke with J.F. and to continue talking to him. Later, she and her colleague had asked J.F. once again whether he had taken methadone, which he had still denied. The prison had no observation cell as such, but the disciplinary cells had been used for observation because their location was close to the staff office. She felt certain that J.F. would have told her if he had taken something.

If J.F. had asked to see a doctor, they would have contacted a doctor. When she had left work that day, she had not believed that something had been seriously wrong.

28. In addition, the High Court had before it an “observation sheet for use by staff when dealing with an intoxicated client”, dated 16 November 2017, signed by L.R., according to which – in the box “What has the doctor instructed staff to observe (level of consciousness, breathing, etc.), and what signs of deterioration (increased tiredness, shallow breathing, etc.) must staff respond to? Describe:” – L.R. had written, *inter alia*, “If the inmate deteriorates, the on-call doctor must be called for”.

29. By a judgment of 16 March 2023, the High Court found against the applicants for the following reasons:

“According to the autopsy report of 21 November 2017 on J.F., [his] general practitioner had stated that J.F. had a history of comprehensive abuse of, *inter alia*, benzodiazepines.

J.F. was serving a prison sentence in the Kragsskovhede Prison under an ordinary regime, and there is no information indicating that he was suicidal at the time. Based on the evidence produced, including the statements given by inmate M.V.T. and prison officers M.B., P.M. and J.P., the High Court considers it a fact that, during his incarceration in Kragsskovhede Prison, J.F. often appeared to be under the influence of medicine or drugs.

The High Court further considers it a fact that, when informed by M.V.T. that J.F. had allegedly stolen a bottle of methadone tablets from the nurse, prison officer L.R. had approached J.F. and transferred him to the prison’s medical unit because he had made the assessment that J.F. was severely intoxicated and that it was necessary to look into the matter further. In the medical unit, prison officer M.B. had multiple conversations with J.F. Based on those conversations and on J.F.’s behaviour in general, including that he was able to light a cigarette, find some books in the library, open doors and walk without staggering, M.B. made the assessment that J.F.’s level of intoxication was not higher than it had been when he had seen him earlier that day. During the course of events, prison officers L.R., M.B. and J.P. asked J.F. multiple times whether he had taken drugs, which he denied, but he said to L.R. that the prison nurse had given him some medicine because of a dental abscess and that it was that medication that had made him feel unwell. L.R. contacted the prison nurse, who confirmed that J.F. had been given medication. The nurse instructed L.R. to keep J.F. under observation and to call a doctor if his condition deteriorated. Prison officer M.B. stated before the High Court that he had asked J.F. multiple times whether he had wanted to be examined by a doctor, which J.F. had declined. Based on the evidence given by prison officer P.M., the High Court accepts as facts that [J.F.] was subsequently observed at least on an hourly basis and that they had no reason to presume that [J.F.]’s condition had been deteriorating.

On that basis, the High Court finds that the assessment of [J.F.]’s condition made by staff of the Prison and Probation Service (*Kriminalforsorgen*) and the discretionary decision made by said staff in that connection did not mean that the Prison and Probation Service were responsible for the death of [J.F.] Based on an overall assessment of the information of the case, the High Court has not accorded crucial importance to the circumstances that, on 16 November 2017 at 8:45 p.m., the prison staff searched [J.F.]’s cell, where the staff found ‘a piece of cardboard with two lines

prepared' and that the nurse did not call a doctor. Based on the above concerning the responsibility of the Prison and Probation Service in connection with the death of [J.F.] and on the information on file, the High Court finds that, with the information available at the time, the actions of the Prison and Probation Service did not act contrary to the obligations following from Article 2 of the European Convention on Human Rights as interpreted by the European Court of Human Rights, *inter alia*, in *Marro and Others v. Italy* (no. 29100/07, §§ 41 and 42, 8 April 2014) and in *Patsaki and Others v. Greece* (no. 20444/14, § 88, 7 February 2019) or from Article 3.

Consequently, the allegations made by [the wife of J.F.], [the daughter of J.F.] and [the mother of J.F.] against the Prison and Probation Service in Central and Northern Jutland are dismissed ...”

30. On 14 September 2023 the Appeals Permission Board (*Procesbevillingsnævnet*) refused to grant leave to appeal to the Supreme Court (*Højesteret*).

RELEVANT LEGAL FRAMEWORK AND PRACTICE

I. DOMESTIC LAW AND PRACTICE

A. The Sentence Enforcement Act

31. The enforcement of sentences is governed by the Danish Sentence Enforcement Act (*straffuldbyrdelsesloven*) (at the relevant time Act no. 1242 of 11 November 2015).

B. Rules on searches of inmates' cells and their persons

32. The rules on searches of inmates' cells and their persons, including on urine sampling, are set out in sections 60 and 60a of the Sentence Enforcement Act. Section 60 provides that the Prison and Probation Service may carry out a search without a court order to determine the items in an inmate's possession in his or her cell or on his or her person if deemed necessary in order to ensure the observance of prison rules or for security reasons. The Prison and Probation Service may also decide, pursuant to section 60a, that an inmate must undergo urine testing for controlled substances.

33. The interpretation of the rules on urine sampling in section 60a of the Sentence Enforcement Act is given in Guidance Note no. 9818 of 18 August 2016 on searches of inmates' cells and their persons in Prison and Probation Service facilities (*vejledning nr. 9818 af 18. august 2016 om undersøgelse af indsattes person og opholdsrum i kriminalforsorgens institutioner*). The circumstances in which it is possible to require an inmate to provide a urine sample are described in clause 10 of the Guidance Note on searches, including when there is a specific suspicion that an inmate has taken controlled substances.

34. The Sentence Enforcement Act was supplemented by Executive Order no. 1110 of 17 August 2016 on searches of inmates' cells and their persons in Prison and Probation Service facilities (*bekendtgørelse nr. 1110 af 17. august 2016 om undersøgelse af indsatte person og opholdsrum i kriminalforsorgens institutioner*).

C. Rules on placement in an observation cell

35. The statutory conditions for the exclusion of inmates from association with other prisoners are specified in sections 63 and 64 of the Sentence Enforcement Act. These sections describe the situations in which it is possible to exclude an inmate from association with other prisoners, including by placing him or her in an observation cell or his or her own cell.

36. Executive Order no. 429 of 9 April 2015 on the exclusion of inmates from association with other prisoners, including by placement in observation cells, etc., in State and local prisons (*bekendtgørelse nr. 429 af 9. april 2015 om udelukkelse af indsatte fra fællesskab, herunder anbringelse i observationscelle m.v., i fængsler og arresthuse*) sets out in section 16(1)(iii) that an inmate can be placed in an observation cell only if special observation is required, and in section 17 that an inmate can only be placed in a cell approved as an observation cell by the Prison and Probation Service.

37. It further follows from section 20 of Executive Order no. 429 that a doctor must be called to attend to an inmate if there is any suspicion of disease or injury in connection with their placement in an observation cell. It further follows from section 20 that a search must be carried out of the inmate's person in connection with the placement unless it is deemed unnecessary by the Prison and Probation Service.

38. It follows from clause 8 of Guidance Note no. 9229 of 13 April 2015 on the exclusion of inmates from association with other prisoners (*vejledning nr. 9229 af 13. april 2015 om udelukkelse fra fællesskab*), concerning the observation of inmates placed in an observation cell, that the frequency of those observations must be determined following an assessment of the specific circumstances. In some cases, there may be a need to check on the inmate at rather short intervals, while checks at longer intervals will suffice in other cases.

D. Rules on medication in prisons

39. Circular no. 53 of 5 July 2011 on the dispensing of medicines, etc., to inmates of State and local prisons (*cirkulære nr. 53 af 5 July 2011 om medicinudlevering m.v. til indsatte i fængsler og arresthuse*) is a binding regulation applicable to all State and local prisons which governs the storage of medicines, among other things. It appears from section 12 that the procurement and use of medicines in Prison and Probation Service facilities

must be registered. Moreover, it follows from section 13 that all medicines must be stored in special medicine cabinets that cannot be accessed by inmates.

40. Executive Order no. 1109 of 30 June 2020 on medicine cupboards or rooms and over-the-counter medicines in Prison and Probation Service facilities (*bekendtgørelse om medicinskabe eller rum- samt håndkøbslægemidler i kriminalforsorgens institutioner*), which came into force on 4 July 2020, allows nasal spray containing naloxone to be stored as a common medicine in a safe storage area (medicine cabinet) if there is formal authorisation from the responsible chief physician. Previously, this was not possible unless it had been prescribed for an individual inmate for storage in that person's medicine box.

E. Internal regulations of Kragshovede Prison

41. At the time of the events, the rules mentioned above were supplemented by the specific internal regulations of Kragshovede Prison, such as setting out procedures for the dispensing of medicines and dealing with and the visual observation of inmates suspected of being intoxicated.

42. It follows from Instruction Note no. 39 of 18 September 2015 of the dispensing of medicines (*instruks nr. 39 af 18. september 2015 om medicinudlevering*) that medications prescribed by a doctor and non-prescription medications may be dispensed. Five fundamental principles must be observed in connection with the dispensing of medications to ensure that the right patient is given the right dose of the right medication at the right time and in the right manner.

43. Instruction Note no. 104 on dealing with an intoxicated client (*instruks nr. 104 af 21. juli 2014 om håndtering af den påvirkede klient*) divides inmates into the categories of "critically intoxicated clients" and "other intoxicated clients" based on their level of intoxication. "Other intoxicated clients" comprises any client whose appearance or behaviour has changed significantly from what is usually observed for that client. Symptoms may be that the person dozes off, but can be woken up again, that the person starts sweating and becomes pale, or that the person suddenly starts rambling or having balance issues or delusions. Such symptoms should always raise concerns about that inmate's condition, and the inmate should always be discussed by healthcare professionals. If a nurse is involved in such a discussion, he or she must contact a doctor, as only doctors are able to determine the reason for a general condition of intoxication and decide on the need for observation and treatment going forward.

44. A medical assessment must be carried out for each individual to determine whether they require observation by staff, and whether it is reasonable to let the inmate remain at the relevant Prison and Probation Service facility, taking into account the possibilities of observation, or

whether the inmate should be hospitalised. When an intoxicated inmate remains at the prison for continued observation, a written plan and guidance notes (“the observation sheet for use by staff when dealing with ‘an intoxicated client’”) must always be filled in following the consultation of a doctor/an on-call emergency doctor. The observation sheet must describe where observations are to be made (for example in an observation cell), the minimum time between observations, what is to be observed by staff (for example level of consciousness, breathing) and the specific actions to be taken in relation to those observations (such as contact the doctor or hospitalisation).

45. It follows from Instruction Note no. 48 of 2 January 2012 on the reporting of inmates deemed intoxicated as well as measures to be taken (*instruks nr. 48 af 2. januar 2012 om indberetning af indsatte, der bl.a. skønnes påvirkede samt foranstaltninger heroverfor*) that inmates deemed intoxicated by alcohol, drugs or medications, for example, and in need of dedicated observation must be placed in an observation cell pursuant to section 64(1)(i) of the Sentence Enforcement Act for observation for a suitable period, usually until the inmate is no longer deemed to be intoxicated. An “observation cell report” must be created in the “client system”, the case management system of the Prison and Probation Service, and a dedicated observation sheet must be filled in. The inmate must be observed at regular intervals, and entries must be made of the inmate’s condition. Highly intoxicated inmates must be observed frequently, about once every 15 minutes. If there are any indications that the inmate’s general condition is deteriorating – for example he or she is displaying one of the following: respiratory difficulties, loss of consciousness, hallucinations or serious vomiting – the prison nurse must be contacted.

46. At the time of the events, Kragsskovhede Prison did not have any approved observation or safety cells. It follows from Instruction Note no. 50 of 14 September 2015 on the placement in observation or safety cells (*instruks nr. 50 af 14. september 2015 om anbringelse i observations- eller sikringscelle*) that the cells in the disciplinary and segregation unit of the prison could be used for temporary placement, but that inmates in temporary placement had to be transferred to an approved cell as soon as possible, the closest approved cell being in Aalborg Local Prison. It further appears from the instruction note that a dedicated observation sheet as mentioned in paragraph 60 of that note had to be created (in addition to an “observation cell report” in the client system) in connection with temporary placements and that everyone observing the relevant inmate had to write down information about the inmate’s condition on the observation sheet.

II. REPORTS OF THE EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT (CPT)

47. In its report of 12 December 2024 (CPT/Inf (2024) 38), covering the CPT's visit to Denmark from 23 May to 3 June 2024, the CPT reiterated much of its previous recommendations and criticised the general healthcare provided in Danish prisons, in particular in relation to the availability of healthcare, lack of medical confidentiality in prisons and also in relation to its quality. Reference is made to section 4 of the report. In particular, regarding medication in the event of an opioid overdose, it stated as follows:

“Another issue of serious concern is that easily administered life-saving medication (in case of opioids overdose) such as naloxone in the form of nasal spray, was prohibited in prisons. The delegation was told that the Patients' Security Agency which oversees health care in prisons, and the National Healthcare Authority opposed its use on the grounds that opioids used by prisoners were not prescribed by doctors, and it would be incorrect to make medication such as antidotes available as a response to the illegal use of drugs.

The Committee finds this reasoning surprising to say the least, and somewhat in denial of the reality. Whether the substances were legally prescribed or not, prisoners did [*sic*] use opioids and risked [*sic*] death from overdose. Providing staff (not only health-care staff but also custodial officers) with naloxone, to be used only in case of emergency, could save prisoners' lives.

The CPT recommends that steps be taken to make naloxone nasal spray available to both health-care and custodial staff (and to train the latter in how to administer naloxone in case of emergency).”

THE LAW

ALLEGED VIOLATION OF ARTICLES 2 AND 3 OF THE CONVENTION

48. The applicants complained that the Danish Prison authorities had failed to provide J.F. with adequate supervision and medical care and, accordingly, to protect his life, in breach of Articles 2 and 3 of the Convention.

49. As a master of the characterisation to be given in law to the facts of the case before it (see *Radomilja and Others v. Croatia* [GC], nos. 37685/10 and 22768/12, §§ 114 and 126, 20 March 2018), the Court considers that the applicants' complaints should be examined only under Article 2 of the Convention, the relevant part of which reads as follows:

“Everyone's right to life shall be protected by law ...”

A. Admissibility

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

51. The applicant disagreed.

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

B. Merits

1. Arguments by the parties

(a) The applicants

53. The applicants submitted that the prison authorities had known or ought to have known that J.F. had been at real and immediate risk of losing his life. They referred, among other things, to the fact that M.V.T. had alerted the prison officer L.R. that J.F. had taken a bottle with 100 methadone tablets from the infirmary, and had taken too many of those tablets; the nurse had confirmed that the infirmary had been in possession of such bottles; and L.R. had found J.F. severely intoxicated.

54. Nevertheless, in the applicants' view, the prison authorities had failed to act appropriately when made aware of the risk to J.F.'s life. They reaffirmed that the Prison and Probation Service itself on 17 January 2020 (see paragraph 15 above) had identified many mistakes, without which the risk could have been mitigated.

55. The applicants pointed out that a doctor had not been contacted; there was no evidence that J.F. had refused to see one; the nurse had not attended to J.F.; she had also failed to indicate how often J.F. had needed to be checked on while placed in the medical unit; the prison staff had not asked J.F. to provide a urine sample; a number of provisions of Circular no. 53 of 5 July 2011 (see paragraph 39 above) had not been observed; the prison had not had a medicine storage system (which was the reason why it could not be determined if a bottle had gone missing); the substance in J.F.'s cell had not been secured and analysed; J.F. had not been formally searched; and the prison did not have a proper observation cell in which J.F. could have been properly observed, nor had he been transferred to another prison with a proper observation cell. In addition, as noted by the CPT during their last visit in 2024 (see paragraph 47 above), "surprisingly" Danish prisons were not in possession of the most basic antidote, naloxone, to be administered in the event of an opioid overdose, including from methadone.

(b) The Government

56. The Government maintained that there had been no violation of Article 2 of the Convention. They referred in particular to the finding of facts and the assessment carried out by the domestic courts.

57. The Government pointed out that there had been no indication that J.F., who had been a known addict, had been suicidal or had had a deliberate desire to overdose. Moreover, the prison officers could not have known that J.F.'s life had been in danger. The prison officers had been used to seeing J.F. under the influence of drugs and medicine, and even after they had been made aware that he might have stolen and taken some methadone tablets, they had closely monitored him for several hours. In particular, prison officer M.B. had verified that J.F. could walk, light and smoke a cigarette, and find books in the library. M.B. had asked J.F. if he had taken anything, to which J.F. had responded no, apart from the penicillin in the morning. M.B. had patted J.F.'s pockets and had found nothing. Accordingly, M.B. had found no reason to find J.F.'s level of intoxication alarming. Thereafter, the prison staff had observed J.F. hourly, but had not noticed any alarming signs.

58. The Government accepted that minor administrative errors had been committed and that the procurement and use of medicine ought to have been registered according to the Circular on the dispensing of medicines but emphasised that such an omission could not by itself reach the threshold required by Article 2.

59. The Government also acknowledged that sections 60 and 60a of the Sentence Enforcement Act could have authorised a formal search and the taking of a urine sample from J.F., but maintained that such measures would not necessarily have been needed or have had an impact on the case. What mattered was how the prison officers had managed the situation as from around 8 p.m. based on the information about the potential consumption of methadone.

60. The Government argued that the assessments and actions of the prison staff had been reasonable and adequate in view of the information available at the relevant time. They had consulted the nurse several times, transferred J.F. to the medical unit, monitored his behaviour, placed him in a temporary observation cell situated very close to the staff office, offered to call a doctor (which J.F. had refused) and checked on him hourly. In conclusion they had taken all the measures that they could have reasonably been expected to take to secure J.F.'s health and well-being, and to mitigate the risk of his loss of life.

61. The Government further submitted that it is prohibited to possess drugs and controlled substances in Danish prisons, including methadone, oxycodone and fentanyl, as found in the forensic toxicology report concerning J.F. (in addition to benzodiazepines, which may have been prescribed). Accordingly, J.F.'s death had been caused by an overdose of medications that J.F. had obtained in violation of criminal law.

62. In addition, the dispensary at Kragshovede Prison was fitted with locked cabinets for dangerous medicines behind the counter on the staff side. The nurse had not noticed any dangerous medicines out of the cabinet when she had left for a few seconds to get a sticky note, therefore her actions had been within the scope of the regulations, and she could not be blamed if J.F. had stolen a bottle of tablets during her short absence. The Government further stressed that it had never been concluded with any certainty that a bottle of tablets had been stolen.

2. *The Court's assessment*

(a) **General principles**

63. Together with Article 3, Article 2 of the Convention enshrines one of the basic values of the democratic societies making up the Council of Europe. The object and purpose of the Convention as an instrument for the protection of individual human beings requires that its provisions be interpreted and applied so as to make its safeguards practical and effective (see, among many other authorities, *Salman v. Turkey* [GC], no. 21986/93, § 97, ECHR 2000-VII; *Giuliani and Gaggio v. Italy* [GC], no. 23458/02, §§ 174 and 177, ECHR 2011 (extracts); and *T.V. v. Croatia*, no. 47909/19, § 46, 11 June 2024).

64. In the light of the primary duty on the State to secure the right to life under Article 2, the Court must subject allegations of a breach of this provision to the most careful scrutiny, taking into consideration not only the actions of State agents but also all the surrounding circumstances – including such matters as the relevant legal or regulatory framework in place and the planning and control of the actions under examination (see *Makaratzis v. Greece* [GC], no. 50385/99, §§ 57-59, ECHR 2004-XI; *Tekin and Arslan v. Belgium*, no. 37795/13, § 84, 5 September 2017; and *Machalikashvili and Others v. Georgia*, no. 32245/19, § 99, 19 January 2023). The Court further emphasises that persons in custody are in a vulnerable position and the authorities are under an obligation to account for their treatment. The Court has also held that the obligation to protect the health and well-being of persons in detention clearly encompasses an obligation to take reasonable measures to protect them from harming themselves. As a general rule, the mere fact that an individual has died in suspicious circumstances while in custody should raise an issue as to whether the State has complied with its obligation to protect that person's right to life (see *Ainis and Others v. Italy* no. 2264/12, 14 September 2023, § 54, and the cases cited therein).

65. However, this obligation must be interpreted in such a way as not to impose an unbearable or excessive burden on the authorities, bearing in mind, in particular, the unpredictability of human behavior and the operational choices to be made regarding priorities and resources. For a positive obligation to arise, it must be established that the authorities knew or ought

to have known at the time that a given individual was facing a real and immediate threat to his or her life and that they failed to take, within the scope of their powers, the measures which would reasonably have mitigated that risk (see, *Patsaki and Others v. Greece*, no. 20444/14, § 87, 7 February 2019, and the cases cited therein).

66. In addition, even where it is not established that the authorities knew or ought to have known about any such risk, there are certain basic precautions which police officers and prison officers should be expected to take in all cases in order to minimise any potential risk to protect the health and well-being of the arrested person (see, among others, *Daraibou v. Croatia*, no. 84523/17, § 84, 17 January 2023, and the cases cited therein, and *Ainis and Others*, cited above, § 58).

67. Moreover, with regard to persons deprived of their liberty, the Convention imposes on the State a positive obligation to ensure, *inter alia*, that the health and well-being of the prisoner are adequately protected and to provide prompt medical care, where the person's state of health so requires, in order to prevent a fatal outcome (see *Patsaki and Others*, cited above, § 88, and the cases cited therein).

(b) Application of those principles to the present case

68. The Court notes from the outset that it is not in dispute between the parties that it was prohibited to be in possession of or under the influence of illegal drugs at Kragsskovhede Prison.

69. Moreover, the applicants did not complain about the availability of drugs in Danish prisons (contrast, for example, *Marro and others v. Italy* (dec.), no. 29100/07, §§ 24 and 45, 8 April 2014).

70. The Court also notes that investigations were initiated and that an autopsy was conducted shortly afterwards. The applicants did not submit that those investigations had been insufficient or otherwise incompatible with the Convention (*ibid.*, § 48).

71. The issue for the Court is therefore whether the prison authorities knew or ought to have known that J.F. was at real and immediate risk of losing his life, and in the affirmative, whether they failed to take, within the scope of their powers, measures which, judged reasonably, might have been expected to avoid that risk, including providing prompt medical care.

72. Before the District Court, J.F.'s mother and wife, fellow inmate M.V.T, and prison officer M.B. gave evidence. Based on the autopsy report, viewed in conjunction with the testimony of M.V.T., the District Court found it established that J.F. had come into possession of a significant quantity of methadone originating from the prison on the morning of 16 November 2017; that he had taken a large quantity of that substance during the day; and that he had died from poisoning by methadone and other substances. The District Court found that it ought to have been clear to the prison staff that there had been a significant risk that J.F. had taken an overdose of methadone. In those

circumstances, and because a doctor had not been called to attend to J.F., the prison staff had not acted as could reasonably be expected in the given situation, and thus had not met the obligation incumbent on the Prison and Probation Service to protect J.F.'s life. However, when awarding damages for non-pecuniary damage, the District Court took into account that "J.F. showed great contributory negligence by taking the tablets of which he had come into possession and that nothing indicates that he intended to harm himself" (see paragraph 22 above).

73. Before the High Court, three additional witnesses were heard, namely prison officers L.R, P.M. and J.P., in addition to J.F.'s mother, his wife and M.B., who gave supplementary testimony.

74. The High Court also had before it an observation sheet, dated 16 November 2017, signed by L.R., according to which – in the box "What has the doctor instructed staff to observe (level of consciousness, breathing, etc.), and what signs of deterioration (increased tiredness, shallow breathing, etc.) must staff respond to? Describe:" – L.R. had written, *inter alia*, "If the inmate deteriorates, the on-call doctor must be called for" (see paragraph 28 above).

75. Based on the evidence before it, the High Court found that the actions of the Prison and Probation Service at the relevant time had complied with the obligations stemming from Article 2 (and 3) of the Convention (see paragraph 29 above). It found it established that J.F. had had a history of comprehensive abuse of, *inter alia*, benzodiazepines and that he had often appeared to be under the influence of medicine or drugs. Moreover, on the day of the incident, when assessing whether J.F. had been severely intoxicated, prison officer L.R. had transferred him to the prison's medical unit. There prison officer M.B. had had multiple conversations with him. Based on those conversations and on J.F.'s behaviour in general, including that he had been able to light a cigarette, find some books in the library, open doors and walk without staggering, M.B. had made the assessment that J.F.'s level of intoxication had not been higher than it had been when he had seen him earlier that day. Confronted with the suspicion of the prison officers that he had taken methadone, J.F. had continuously denied having taken any drugs except from the medication for his dental abscess, and that it had been that medication that had made him feel unwell. He had refused to see a doctor. The nurse had instructed L.R. to keep J.F. under observation and to call a doctor if his condition deteriorated. J.F. had been observed on an hourly basis, and the prison staff had had no reason to presume that J.F.'s condition had been deteriorating.

76. The Court is satisfied that the domestic courts thoroughly examined the case in the light of the Court's case-law, including *Patsaki and Others* (cited above). It reiterates that in that case it found no violation as regards the substantive limb of Article 2, because the prison authorities had not had sufficient facts at their disposal to suggest that the prisoner in question had

been in a situation of particular danger on the day before his death, or that he had faced a potentially greater risk than any other drug-addicted prisoner of undergoing fatal consequences (ibid., § 95).

77. The Court also accepts that in the present case some facts could not be fully clarified. For example, it could not be established with certainty whether a bottle of 100 tablets of methadone had gone missing from the infirmary on the morning of 16 November 2017 (see paragraph 10 above). A bottle was never found. In addition, provided that J.F. had stolen such a bottle, and although M.V.T. alleged that J.F. had taken “too many of those tablets”, it remains unknown how many methadone tablets he actually ingested. It is also not known how he obtained the other drugs found in his blood.

78. In this connection, the Court observes that the autopsy reports of 11 and 15 January 2018 revealed that J.F. had taken not only methadone, but also oxycodone, fentanyl and benzodiazepines (see paragraphs 11 and 12). Methadone, fentanyl and oxycodone are all opioids. They were detected in concentrations “that can be seen, when combined, in connection with treatment or severe or lethal poisoning. The symptoms of poisoning are impaired consciousness, shortness of breath and, as far as methadone is concerned, cardiac arrhythmia. Persons taking opioids daily acquire tolerance, and therefore the risk of poisoning is highly individual. In the relevant case, the deceased was not treated with opioids on a regular basis.”

79. It is noteworthy that the Prison and Probation Service itself identified and acknowledged various errors committed in the present case (see paragraph 15 above), a finding with which the Parliamentary Ombudsman agreed (see paragraph 16 above). Thus, it was noted that Kragshovede Prison had not meticulously followed Instruction no. 104 of 21 July 2014 on dealing with an intoxicated client (see paragraph 43 above), in particular the nurse had not contacted a doctor and she had not arranged for J.F. to be observed at set times. The Prison and Probation Service also expressed criticism of the following aspects: there was no stock management or monitoring of the stock of medicines in the prison (which could have helped clarify whether anything had been missing); J.F. had not been formally searched when he had arrived at the medical unit; the substance discovered in J.F.’s cell had been destroyed and therefore could not be analysed; and J.F. had not been asked to provide a urine sample.

80. The Court cannot exclude that various actions might have mitigated the risk of J.F. dying from an overdose. It reiterates, however, that not every alleged risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising (see, for example, *A.P. v. Austria*, no. 1718/21, § 169, 26 November 2024, and *Marro and others v. Italy* (dec.), cited above, § 41), and that for a positive obligation to arise under Article 2 of the Convention, the test is twofold. A positive obligation will arise where it has been established that the authorities knew, or ought to have known at the time, of the existence of a real and immediate

risk to the life of an identified individual and, if so, that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (see *A.P. v. Austria*, cited above, § 169).

81. In the Court's view, it would certainly have been prudent to call a doctor. It is mindful, though, that J.F. displayed no behaviour conducive to self-harm, or other alarming signs (contrast, *Ainis and Others*, cited above, §§ 5, 6, 8, 21 and 58). Moreover, he had a history of comprehensive abuse of, *inter alia*, benzodiazepines and often appeared to be under the influence of medicine or drugs. In accordance with the rules on medicine, he could therefore be considered to have acquired a certain tolerance (see paragraphs 12, 29 and 75 above). The fact that, according to prison officer L.R., J.F. appeared severely intoxicated at around 7.40 p.m. (see paragraph 25 above) was therefore not unusual.

82. More importantly, later on, after arriving at the medical unit and being observed by prison officers M.B., J.P. and P.M., he appeared intoxicated, "but not more severe than usual", and the intoxication was "wearing off" (see paragraphs 20, 26 and 27 above). Accordingly, the prison officers did not suspect that "anything was wrong". M.B. testified that he would have called a doctor if he had had any indication that something had been wrong. In those circumstances, he would always call for a doctor. Moreover, he had asked J.F. multiple times whether he had wanted to see a doctor, but J.F. had declined (see paragraph 24 above).

83. Nevertheless, the prison staff did take basic precautions in order to minimise any potential risk to protect the health and well-being of J.F. (see paragraph 66 above). Shortly after 7.40 p.m., when prison officer L.R. realised that J.F. might have taken "too many methadone tablets", he immediately placed J.F. in the prison's medical unit. He and prison officer M.B. contacted the nurse, who instructed them to keep J.F. under observation, and to call a doctor if J.F.'s condition deteriorated (see paragraphs 20, 25 and 28 above). Until he went to bed around 9.20 p.m., J.F. was kept under close observation, notably by M.B., who had multiple conversations with him, and followed him when smoking, finding books in the library, opening doors and walking. Thereafter J.F. was checked on every hour.

84. The Prison and Probation Service also expressed criticism of the fact that there was no monitoring of the stock of medicines in the prison. This was also addressed by the Danish Patient Safety Authority (see paragraph 14 above) and led to Kragsskovhede Prison tightening its procedures for entry into the dispensary, refurbishing it and introducing a new stock management procedure for medicines (see paragraph 17 above). The Court fully agrees that a better monitoring of the stock of methadone could have helped clarify rather quickly whether a bottle of methadone tablets had gone missing, which could have supported the suspicion that J.F. had taken it. The Court accepts though, that the dispensary at Kragsskovhede Prison was fitted with locked cabinets for dangerous medicines (see paragraph 10 above), and that a better

monitoring system could not have prevented human error such as the nurse being briefly distracted and thus allowing an inmate to steal medicine.

85. Likewise, regarding the criticism that the substance discovered in J.F.'s cell had been destroyed and therefore could not be analysed, the Court considers, in relation to the examination of the present case, that even analysed, it is not clear whether such information could have cast light on the nature and amount of drugs and substances that J.F. had already ingested (see paragraphs 15-16 above).

86. The prison officers did not formally search J.F. at the medical unit but instead checked his clothes/patted his pockets, and M.B. had not been able to force J.F. to submit to urine testing (see paragraphs 20 and 24 above). M.B. assessed that J.F. would have been less inclined to talk to him if forced to submit to a body search. He had been more interested in J.F.'s well-being and willingness to admit if he had taken anything. It is not for the Court to assess whether such coercive measures, which would have infringed on J.F.'s personal autonomy, would have been justified. It notes, however, that there were no elements indicating that J.F. took any substances with him to the prison's medical unit, or later ingested those substances. Furthermore, although a urine test could have confirmed whether J.F. had taken an overdose of methadone or other drugs, in accordance with the rules of medicine, the effect of the drugs would nevertheless have depended on the tolerance level of the individual concerned (see paragraph 11 above).

87. The applicants have raised the question of the lack of availability of naloxone, which could have been administered as an antidote. The Court notes that this was not raised before the domestic courts. Accordingly, no evidence has been provided to indicate whether naloxone was available at the relevant time, and whether it could possibly have made a difference in the treatment of J.F.

88. Lastly, the Court cannot ignore that on the day in question, J.F. illegally came into possession of various drugs (methadone, fentanyl, oxycodone and benzodiazepines). There was no indication of an intentional self-harm. He appears to have taken an overdose by accident. Nevertheless, despite being cared for at the prison's medical unit, J.F. constantly denied having taken any drugs. He insisted that he might appear unwell or intoxicated owing to the medication he had taken that morning for a dental abscess (see paragraph 25 above). In addition, he refused medical attention multiple times (see 24 paragraph above). He therefore significantly contributed to the perception of the prison officers that he was not facing a real and immediate threat to his life.

89. In the light of all the considerations above, the Court has no reason to question the High Court's finding that, with the information available at the time, when J.F. was taken to the medical unit, assessed and observed hourly, the prison authorities had no reason to presume that his condition was deteriorating. In other words, they did not know or could not have known that

J.F., who, as noted above, “had a history of comprehensive abuse of, *inter alia*, benzodiazepines and ... had often appeared to be under the influence of medicine or drugs” and therefore, in accordance with the rules of medicine, could be considered to have acquired a certain tolerance (see paragraphs 12, 29 and 75 above), was so intoxicated that there was a real and immediate risk that he would lose his life. In that regard the present case is similar to *Patsaki and Others* (cited above). Moreover, the prison staff took certain basic precautions in order to minimise any potential risk to protect the health and well-being of J.F. (contrast, *Daraibou v. Croatia*, cited above, § 84 and *Ainis and Others*, cited above, §§ 58-65). Accordingly, the Court does not need to proceed to examine whether the authorities had taken measures which could reasonably have been expected of them, had they known or ought to have known that there was a real and immediate risk that J.F. would lose his life (see, for example, *Fernandes de Oliveira v. Portugal* [GC], no. 78103/14, § 132, 31 January 2019, and *Hasani v. Sweden*, no. 35950/20, § 76, 6 March 2025). The Court has also noted the shortcomings acknowledged by the Danish Patient Safety Authority (see paragraph 14 above) which led to an enforcement notice to ensure safe storage and administration of medicine in the future. The Court also notes the criticisms expressed by the Prison and Probation Service (see paragraph 15 above), in particular that the nurse had not contacted a doctor, and the assessment made by the Parliamentary Ombudsman (see paragraph 16 above).

90. In the light of the foregoing, and being aware of the scope of the case, the Court concludes that there has been no violation of Article 2 of the Convention.

FOR THESE REASONS, THE COURT, UNANIMOUSLY,

1. *Declares* the application admissible;
2. *Holds* that there has been no violation of Article 2 of the Convention.

Done in English, and notified in writing on 25 November 2025, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Simon Petrovski
Deputy Registrar

Lado Chanturia
President

APPENDIX

List of applicants:

Application no. 2390/24

No.	Applicant's Name	Year of birth	Nationality	Place of residence
1.	Birthe RASMUSSEN	1954	Danish	Hjorring
2.	Walaa Gamel Abdellateef ELNAKORY	1984	Egyptian	Alexandria
3.	Romaysa Joseph RASMUSSEN	2012	Egyptian	Alexandria