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Norwegian Parliamentary Ombudsman

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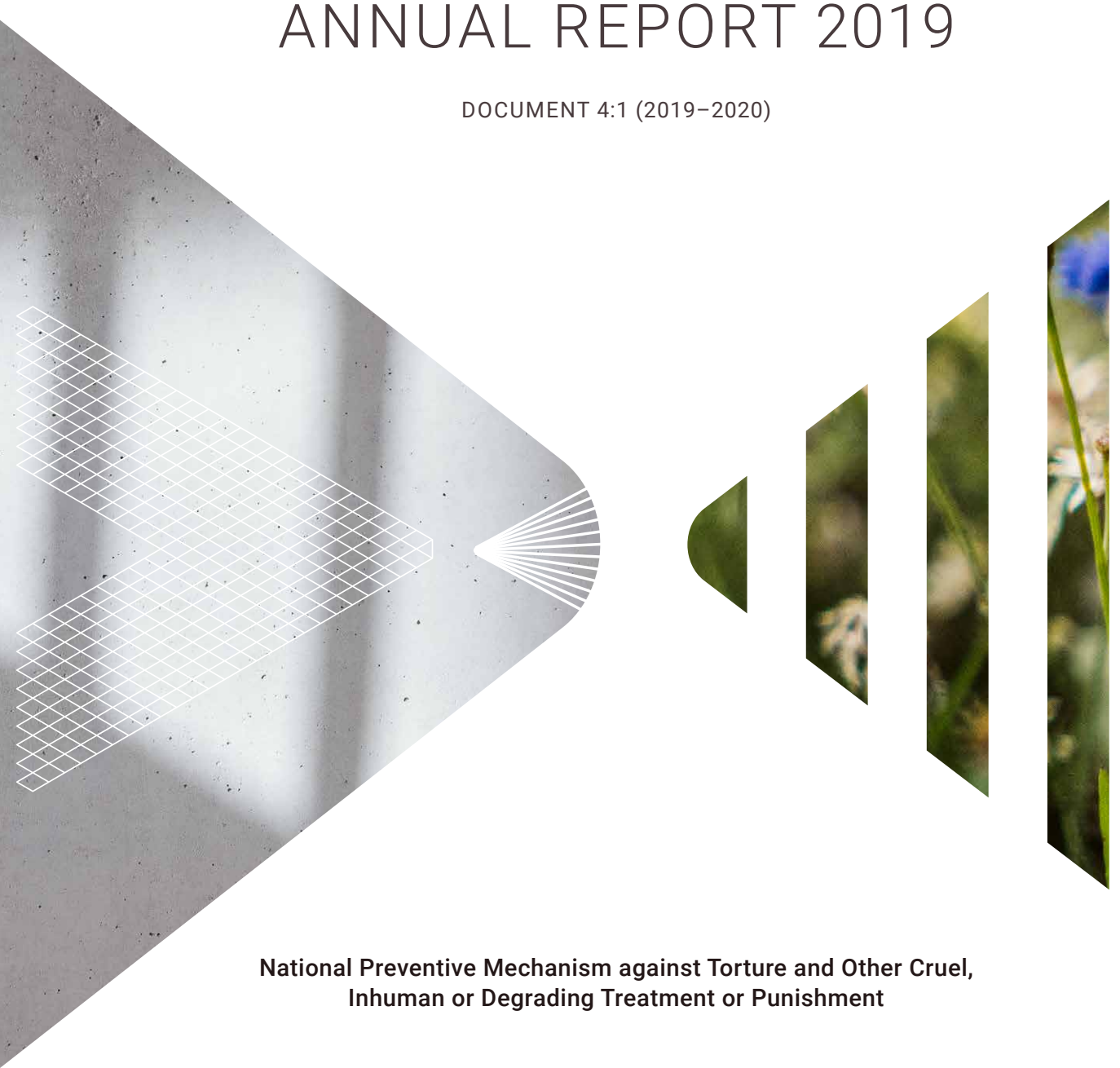

National Preventive Mechanism against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Document 4:1 (2019–2020)

The Parliamentary Ombudsman's Annual Report for 2019 as National Preventive Mechanism against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Submitted to the Storting on 24 March 2020

Preface

This annual report marks the fifth anniversary of the National Preventive Mechanism (NPM). We hereby present some of our achievements since 2014 and highlight some of the overriding issues we consider to be of importance five years down the line. This year has been dominated by the work on the Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons. In addition, we have carried out visits to twelve institutions where children and adolescents are deprived of their liberty.

The Parliamentary Ombudsman's National Preventive Mechanism (NPM) was established in the spring of 2014. The first visit was conducted in September of that year. Five years of prevention work, and over 60 visits to different places in Norway where people might be deprived of their liberty, have yielded results. Previous annual reports have included examples of the results achieved at places we have visited. In this annual report, we dedicate a whole chapter to some of the main results of the prevention work at the national level. Although much of our prevention work takes place in dialogue with the institutions we visit, we want our reports and recommendations to contribute to improving legal safeguards and protection against inhuman treatment for those deprived of their liberty *everywhere* in Norway. We have gathered information about the key results of our work at the national level in Chapter five of this report.

Since 2014, the NPM has carried out 20 visits to 19 of Norway's high-security prisons. The findings regarding solitary confinement and lack of human contact for inmates have been severe across visits, and the situation appeared to be deteriorating, despite our recommendations. With this in mind, we decided in 2019 to use our strongest measure to highlight these issues. The *Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons* was submitted to the Storting's Standing Committee on Scrutiny and Constitutional Affairs on 18 June 2019. This is the Parliamentary Ombudsman's first Special Report to the Storting under its prevention mandate. Much of autumn was spent in dialogue with the authorities regarding the findings in the Special Report. The work on this report to the Storting is presented in more detail in an article in Chapter three.

This year has also seen the completion of a study into the use of restraint beds in Norwegian prisons. Being placed in a restraint bed can pose a considerable risk to both physical and mental health. The European Committee for the Prevention of Torture (CPT) has recommended that restraint beds be removed from Norwegian prisons. Restraint beds are no longer in use in police custody facilities. The Parliamentary Ombudsman has criticised the use of restraint beds in prisons after several visits. The Special Report to the Storting also states that the use of restraint beds constitutes a risk of harm to health, and that inmates in restraints risk being traumatised during an acute life crisis. The results of a comprehensive compilation that included all administrative decisions on the use of restraints in Norwegian prisons over the past six years are presented in a thematic article in Chapter three of this annual report.

The NPM also used findings and experiences from visits to actively participate in public debate and in democratic processes relevant to the prevention of torture and other inhuman treatment in Norway. In 2019, we made four consultation submissions. The Parliamentary Ombudsman made a consultative submission in July on the then Ministry of Children and Equality's draft on a new Child Welfare Act. Our comments concerned the proposal to set out further rules for child welfare institutions. In September, we made another consultation submission concerning the Directorate of Health's proposal to establish national guidelines for medical personnel relating to health services for detainees in police custody facilities. In the same month, we made a consultation submission on the Ministry of Justice and Public Security's proposal to change the Execution of Sentences Act's rules regarding coercive measures. In December, we made a fourth consultation submission in connection with the proposal for a new law on limiting the use of coercion in the health and care services. Our work on the consultation submissions is the topic of a separate article in Chapter three.

Although much of the year has been devoted to a few selected projects, we have carried out twelve visits to places where children and adolescents are deprived of their liberty in child welfare and mental health care institutions. Many of the institutions we have visited are small, which meant that we had to develop our methodology for visits.

Thorough preparation has been key to ensure that the visits were carried out in an appropriate manner and that accurate information concerning the institutions has been received. We have also followed up visits that were carried out in 2018 through dialogue with the respective institutions. This work is described in Chapter five.

There has also been a focus on dissemination in 2019. For the first time, the NPM hosted an event during the political festival "Arendalsuka". This launched the Special Report to a wider audience, with a panel discussion on solitary confinement and lack of human contact in Norwegian prisons. There has been a great deal of interest in the findings we presented in the Special Report, and it is being used by both the responsible authorities and civil society. Furthermore, we have conducted external activities through meetings with central government authorities and other parties. A solid national dialogue will always be an important part of the preventive work.

Hanne Harlem
Parliamentary Ombudsman

Which sectors are covered by the NPM's mandate?

59

PRISONS AND TRANSITIONAL HOUSING

127

DETENTION PREMISES USED BY THE CUSTOMS SERVICE

Approx.
115

POLICE CUSTODY FACILITIES, INCLUDING WAITING CELLS

3

POLICE IMMIGRATION DETENTION CENTRES

9

CUSTODY FACILITIES OF THE NORWEGIAN ARMED FORCES

1

INVOLUNTARY INSTITUTIONAL TREATMENT CENTRE (BRØSET)

68

MENTAL HEALTHCARE INSTITUTIONS

Approx.
70

INSTITUTIONS FOR INVOLUNTARY TREATMENT OF PERSONS WITH SUBSTANCE ABUSE ADDICTIONS

HOUSING FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

The number of places where persons with developmental disabilities can be deprived of their liberty is uncertain. This is due to a variety of reasons, including that many persons with developmental disabilities live in their own home or in sheltered housing facilities. The NPM has yet to carry out visits to this sector and has therefore not finished mapping it.

Approx.
1000

NURSING HOMES

Approx.
150

CHILD WELFARE INSTITUTIONS

The figures are estimates based on a mapping conducted in 2014/2015, and updated in 2019.

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The Parliamentary Ombudsman's Prevention Mandate

On 14 May 2013, the Storting voted in favour of Norway ratifying the Optional Protocol to the Convention against Torture (OPCAT). The Storting awarded the task of exercising the mandate set out in OPCAT to the Parliamentary Ombudsman. In 2014, the National Preventive Mechanism (NPM) was established as a department under the Parliamentary Ombudsman to address this area of the Ombudsman's work.

The Parliamentary Ombudsman, represented by the NPM, conducts regular visits to places where people are deprived of their liberty, such as prisons, police custody facilities, mental healthcare institutions and child welfare institutions. The visits can be both announced and unannounced.

The NPM has the right of access to all places of detention and the right to speak in private with people who have been deprived of their liberty. The NPM also has the right to access all necessary information that is relevant to the conditions of people deprived of their liberty.

During its visits, the NPM will endeavour to identify risk factors for violation by making its own observations and through interviews with the people involved. Interviews with people deprived of their liberty are given special priority.

As part of its prevention efforts, the NPM engages in extensive dialogue with national authorities, control and supervisory bodies in the public administration, other ombudsmen, civil society, NPMs in other countries and international organisations in the human rights field.

An advisory committee has been established that contributes expertise, information, advice and input to the prevention work.

The UN Convention against Torture

The UN Convention against Torture states that torture and inhuman treatment are strictly prohibited, and that no exceptions can be made from this prohibition under any circumstances. States that endorse the convention are obliged to prohibit, prevent and punish all use of torture and other cruel, inhuman or degrading treatment or punishment. According to the Convention, each State party shall 'ensure that its competent authorities proceed to a prompt and impartial investigation, wherever there is reasonable ground to believe that an act of torture [or other cruel, inhuman or degrading treatment or punishment] has been committed in any territory under its jurisdiction'.[1]

Norway ratified the Convention against Torture in 1986. The prohibition against torture is set out in various parts of Norwegian legislation, including Article 93 of the Norwegian Constitution.

The UN Convention against Torture states that torture and inhuman treatment are strictly prohibited, and that no exceptions can be made from this prohibition under any circumstances.

1 The UN Convention against Torture Article 12.

The Optional Protocol to the Convention against Torture (OPCAT)

The Optional Protocol to the UN's Convention against Torture aims to prevent torture and inhuman treatment of people deprived of their liberty. The Optional Protocol was adopted by the UN General Assembly in 2002, and it entered into force in 2006. Central to the protocol is the understanding that people who are deprived of their liberty find themselves in a particularly vulnerable situation and face an increased risk of torture and other cruel, inhuman or degrading treatment or punishment.

States that endorse the Optional Protocol are obliged to establish or appoint one or several National Preventive Mechanisms (NPMs) to regularly carry out visits to places where people are or may be deprived of their liberty, in order to strengthen their protection against torture and inhuman treatment.

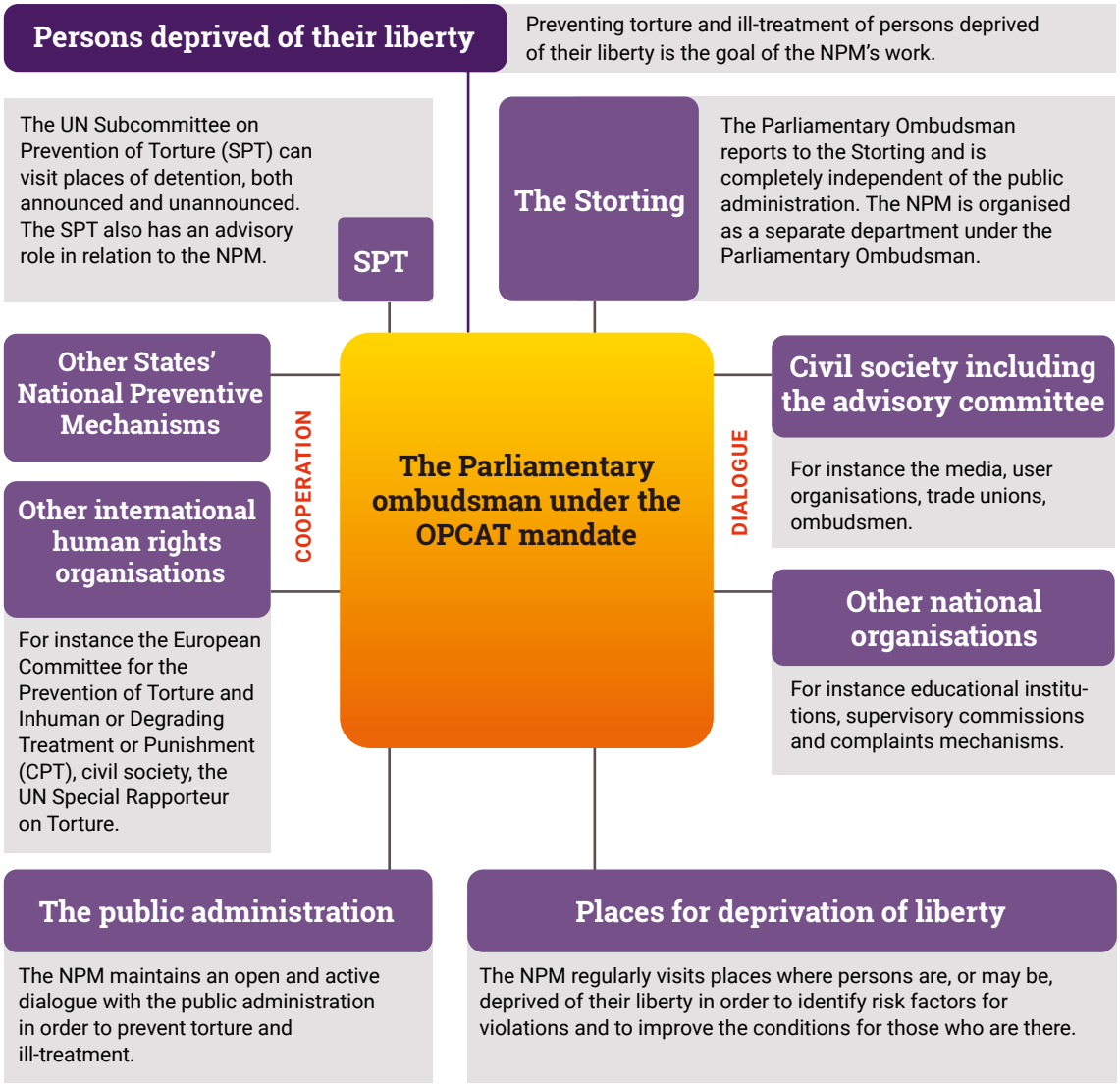
The NPMs can make recommendations that highlight risk factors for violations of integrity. They can also submit proposals and comments concerning existing or draft legislation.

The NPMs must be independent of the authorities and places of detention, have the resources they require at their disposal and have employees with the necessary competence and expertise.

The Optional Protocol has also established an international prevention committee that works in parallel with the preventive mechanisms, the UN Subcommittee on the Prevention of Torture (SPT). The SPT can visit all places of detention in the states that have endorsed the Optional Protocol. The SPT's mandate also includes providing advice and guidance to the national preventive mechanisms.

UN's Convention against Torture aims to prevent torture and inhuman treatment of people deprived of their liberty.

The NPM´s most important relations



Working Methods

The core of our work is to investigate and understand the specific challenges of the places we visit, to make recommendations on how the risk of inhuman treatment can be limited in order to better safeguard the people who have been deprived of their liberty, and to use dialogue as a means of implementing change. In addition to visits, we work strategically with knowledge sharing and advocacy work on a systemic level.

— Effective and credible prevention work depends on our freedom to choose which places we visit, and how and when we carry out the visits. It also requires access to all the persons in and all parts of the institutions we visit, and the opportunity to conduct interviews in private. —

The National Preventive Mechanism's (NPM) main task is to identify the risk of torture and inhuman treatment to prevent people from being subjected to such violations. The risk of torture or inhuman treatment is influenced by factors such as legal and institutional frameworks, physical conditions, training, resources, management and institutional culture.[1]

The NPM has a broad methodical approach. Our primary method is to visit places where people are deprived of their liberty. This gives us the opportunity to speak with the persons deprived of their liberty, and it provides a good insight into the conditions in places in Norway where deprivation of liberty takes place.

1 See the UN Subcommittee on Prevention of Torture (SPT): The approach of the Subcommittee on Prevention of Torture to the concept of prevention of torture and other cruel, inhuman or degrading treatment or punishment under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 30 December 2010 CAT/OP/12/6.

During the NPM's visits, the conditions at the institution are examined through observations, interviews and document reviews.

Good assessment procedures form the basis for a successful visit

The NPM spends a considerable amount of time preparing visits. The prioritisation of the places to visit and when to visit them is based on careful in-depth assessments. To be able to carry out systematic and expedient work, it is crucial that the NPM has access to different sources. A review of relevant documentation before the visit makes it possible to identify potential risk factors of degrading and inhuman treatment. This ensures that the visits address the challenges that are most relevant to the place in question. One particular challenge is that a number of places where people can be placed against their will are established on a needs basis. In many cases, these can resemble small, private homes. This is particularly the case in the child welfare sector, for instance; it has been a challenge to obtain an exhaustive list of all existing institutions.

It is important for the NPM to gain an understanding of the relevant challenges in the different places, in order to be as prepared as possible for each visit. The visits must also be planned to ensure that the NPM's staff can talk to as many people as possible at the institution in question. When we visit large institutions, for example, it is important to plan to ensure that we can conduct as many interviews as possible. When we visit small institutions, it is important that the visit takes place at a time when as many people as possible are available to interview. The number of persons that have been deprived of their liberty, the staff and their shifts and the presence of managers are examples of factors that should be considered when planning a visit.

The NPM prepares adapted interview guides in advance for the different groups we wish to interview during a visit. All conversations take place in the form of partly structured interviews with two members of the NPM present. This ensures that the information we receive during the interviews is adequately documented. In addition to interview guidelines, we also develop documents that examine issues that we expect to find at the institution we are visiting. These can depend on the type of institution, whether it is run privately or by the state, its size and so on.

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In 2019, the Parliamentary Ombudsman's National Preventive Mechanism carried out ten visits to the child welfare sector and two visits to the mental health care sector.

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We do not inform the places we visit about when the visit is scheduled to take place. As a general rule, they are notified that a visit will take place within a period of two to four months, sometimes within a period of up to twelve months. This enables us to gather information from several sources before the visit. Key sources in this phase include documents from the place to be visited, the oversight bodies, official authorities and other relevant bodies.
The Parliamentary Ombudsman has the right of access to all necessary information that is relevant to the conditions in places of detention. Examples include administrative decisions, patient and other relevant records, statistics and internal documents on operations. Sometimes our visits are completely unannounced. These are visits to places where the advantage of arriving unannounced is assumed to be greater than the advantage of being able to collect information ahead of the visit.

Interviews with people deprived of their liberty
During the NPM's visits, the conditions at the institution are examined through own observations, interviews and a review of documentation. We take photos to document physical conditions, information posters and equipment.

The NPM's priority is always to conduct private interviews with the persons who have been deprived of their liberty. These interviews are a particularly important source of information, because the persons deprived of their liberty have first-hand knowledge of the conditions in the place in question. They are in a particularly vulnerable situation and have a special right to protection. Their experiences are an important and relevant source of information. Interpreters are used as required.

Interviews are also conducted with the staff, management, health service and other relevant parties.

After the visit, we obtain further documentation to shed more light on the conditions at the institution, such as routines and procedures, local guidelines, administrative decisions on the use of coercion, logs, plans and health documentation.

All findings are published
The NPM writes a report after every visit. In the reports, we describe findings and risk factors that were uncovered during the visit and make recommendations for changes as needed. The goal of these recommendations is to reduce the risk of people deprived of their liberty being subjected to torture or other cruel, inhuman or degrading treatment or punishment.

All reports are published on the Parliamentary Ombudsman's website. We also send the report to the institution in question and ask that they make the report available to the people deprived of their liberty and the staff.

The places that have been visited are given a deadline for informing the Ombudsman about how the recommendations in the report have been followed up. Their follow-up is also published on the Ombudsman's website.

In 2019, the Parliamentary Ombudsman submitted a Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons. The Special Report is the most powerful instrument available to the Parliamentary Ombudsman.

The NPM's employees as of 31 December 2019
Back, from left: Johannes Flisnes Nilsen, Jannicke Thoverud Godø, Jonina Hermannsdottir, Aina Holmén, Pia Kristin Lande and Mari Dahl Schlanbusch. Front, from left: Mette Jansen Wannerstedt, Parliamentary Ombudsman Aage Thor Falkanger, Helga Fastrup Ervik and Silje Sønsterudbråten. Photo: Mona Ødegård.

Five years of preventive work

The reports and the direct follow-up of the places in question form an important part of the NPM's work. Many of the challenges identified by the Parliamentary Ombudsman, however, are relevant to several institutions and should be raised with a higher level of authority. In 2019, the NPM has therefore had a special focus on collecting some of the most results after five years of preventive work.

In spring 2019, the Parliamentary Ombudsman submitted a Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons. The Special Report is the most powerful instrument available to the Parliamentary Ombudsman. In autumn 2019, we have spent time looking into the findings outlined in this report with different parts of the public administration (see Chapter three). We have also mapped the use of restraint beds in prisons and spent time looking further into the findings we published in thematic articles earlier this year, including the use of coercion in mental healthcare institutions.

Another important aspect of our preventive work is to spread knowledge about our work and our findings, the situation of people deprived of their liberty in Norway and the national risk factors we have identified. We do this by contributing to seminars, giving lectures, providing training and engaging in dialogue with relevant institutions (see Activities in 2019).

International dialogue and cooperation are also important in our preventive work. The NPM cooperates and exchanges information with international human rights bodies. The national preventive mechanisms of other countries are also useful partners, and a special cooperation has been established between the national preventive mechanisms of the Nordic countries (see Chapter seven).

The NPM's staff

The NPM has an interdisciplinary composition and includes staff with degrees in the fields of law, criminology, sociology, psychology, social science and human rights.

The NPM is organised as a separate department under the Parliamentary Ombudsman. The NPM does not consider individual complaints.

External experts

The NPM can call in external expertise for individual visits if this is considered necessary. External experts are assigned to the NPM's visit team during the preparation for and execution of one or more visits. They can also help to write the visit report and provide professional advice and expertise to the visit team. No external experts were consulted in 2019, because the number of visits decreased in order to make time to write the Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons.

The NPM's employees travel in the most environmentally friendly way possible.

Climate friendly preventive work

The National Preventive Mechanism's activities require a great deal of travel and extensive contact with other parties both nationally and internationally. In 2019, we focused on how we can limit our climate footprint within the scope of our work. We therefore choose to travel by train, if possible. If we have to travel by car, we do so in the same car and in electric cars when possible. The NPM also has meeting rooms with video equipment, which means that we can hold digital meetings with parties in locations outside Oslo.

We traveled to Strasbourg by train in November.


E1-120

Selected topics from 2019

Use of Restraint Beds in Norwegian Prisons

Strapping inmates into restraint beds is the most intrusive form of coercive measure at disposal in Norwegian prisons. Eighteen of the thirty-one high-security prisons in Norway have restraint beds. Being put in restraints can pose a considerable risk of both physical and psychological injury. During its visit to Norway in 2011, the European Committee for the Prevention of Torture (CPT) emphasised that removing restraint beds from Norwegian prisons should be a long-term goal. After its visit in 2018, the Committee further emphasised that the restraint beds should be removed from Norwegian prisons in its entirety.[1]

Introduction

Prisons can only use restraint beds to prevent inmates from harming themselves.[2] Being placed in a restraint bed involves being strapped into a bed that is permanently installed in a security cell. Police custody facilities no longer use restraint beds, and their use in mental health-care institutions has long been debated. The Norwegian Official Report NOU 2019:14, Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven], was published in June this year and included a proposal to phase out the use of restraint beds in mental healthcare institutions entirely.[3]

The Parliamentary Ombudsman has criticised the use of restraint beds in prisons following several visits. In the spring of 2019, the Parliamentary Ombudsman submitted a Special Report to the Storting on Solitary Confinement in Norwegian Prisons.[4] The purpose of the report was to make the Storting aware of the risk of violation of the prohibition against torture and inhuman treatment that solitary confinement in prison entails. The report concludes that the use of restraint beds in prisons involves a risk of harm to health, and that inmates placed in restraint beds are often exposed to trauma during an acute life crisis.

1 The CPT's visit to Norway in 2018, [CPT/Inf (2019) 1].

2 The Execution of Sentences Act Section 38 and the Directorate of Norwegian Correctional Service (2002). Guidelines to the Execution of Sentences Act and its Regulations, section 38.7. Revised version of 15 March 2019.

3 Norwegian Official Report NOU 2019:14 (2019). Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven].

4 Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons. Document 4:3 (2018/2019).

The Parliamentary Ombudsman has studied the use of restraint beds in Norwegian prisons in more detail over the past six months. This article looks at some of the most important findings and what they mean.

Method

During the period 2014–2018, the Parliamentary Ombudsman's National Preventive Mechanism (NPM) conducted 20 visits to 19 high-security prisons. Based on these findings, the Parliamentary Ombudsman initiated an investigation into the use of restraint beds in Norwegian high-security prisons for the period 2013–2018.

We asked all of the high-security prisons in Norway to provide information on the number of restraint beds available and to submit the standard operating procedures for their use. We also asked for the total number administrative decisions on the use of restraint beds per year for the period 2013-2018; the duration of use in each decision; and how many decisions applied to the same individual. We conducted a review of all administrative decisions and the pertaining supervision logs.

The prison health service was asked to submit their written procedures for the use of restraint beds. We also asked for a description of how the health service is notified, their tasks in relation to the use of restraint beds, their role when the use is discontinued, and whether they conduct follow-up of inmates after being strapped in a restraint bed. All prisons and prison health services responded to our request for information.

Human rights standards and national legislation

Restraints can only be used as a last resort, for the shortest time possible, and as the only way to prevent the person from inflicting harm on themselves or others.[5]

International law is moving towards a more critical stance on the use of restraints, in particular against people with mental health issues. The UN Special Rapporteur on Torture has recommended that the Member States discontinue the use of restraints entirely for people in that situation. The same applies to the UN Convention on the Rights of Persons with Disabilities.[6] The CPT has also previously recommended avoiding the use of restraint beds outside non-medical settings.[7]

The European Court of Human Rights (ECtHR) has in several cases established that restraints can constitute a violation of the prohibition against torture and inhuman treatment, cf. the European Convention on Human Rights (ECHR) Article 3. The Court currently appears to be applying a stricter review of cases concerning the use of restraints.[8] In its evaluation of whether a violation of Article 3 has taken place, the Court places particular emphasis on the requirements of documentation of adequate reasons, duration, measures that were attempted prior to the intervention and the type of supervision that was carried out.[9]

5 The Mandela Rules, CPT, Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012, section 86 and M.S. v. Croatia (no. 2, application no. 75450/12), judgment of 19 May 2015.

6 The UN Committee on the Rights of Persons with Disabilities (CRPD), Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities, adopted at the committee's 15th session in September 2015, paragraph 12 with further references.

7 See the CPT's visit to Germany in 2015 [CPT/Inf (2017) 13] on the use of Fixierung in prison.

8 Herczegfalvy v. Austria, application no. 10533/83, judgment of 24 September1992 (Chamber), Henaf v. France, application no. 65436, judgment of 27 November 2003, Wiktorko v. Poland, application no. 14612/02, judgment of 31 March 2009, Julin v. Estonia, application no. 16563/08, judgment of 29 May 2012, Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012, M.S. v. Croatia (no. 2, application no. 75450/12), judgment of 19 May 2015.

9 Henaf v. France, application no. 65436, judgment of 27 November 2003, Section 47.

In Norway, the use of restraint beds is regulated by the Execution of Sentences Act Section 38. The Act provides for the use of restraint beds, security cells and other approved measures of restraint, in all situations covered by Section 38. This is not in accordance with the ECtHR's requirements that each decision to use a restraint bed is based on adequate reasons explaining why the decision was made. The Directorate of Correctional Service has specified in the guidelines on the use of restraint beds that this measure must only be employed when strictly necessary to prevent an inmate from harming him or herself.[10]

Under Section 38 second paragraph of the Execution of Sentences Act, restraints shall only be used if the circumstances make this strictly necessary and less intrusive measures have been attempted unsuccessfully or are obviously inadequate. Restraint measures must be used with caution in order to prevent unnecessary harm or suffering. The guidelines stress that the Correctional Service will continually assess whether there is a need to uphold the measure.

In addition, the Act has rules for notifying a doctor and reporting long-term use of restraint beds to the governing authority, as well as separate, stricter rules for the use of restraint beds for persons under 18.

The health service's assistance to a person placed in restraints is regulated in the Health Personnel Act Section 4 concerning professional responsibility and diligent care.

A restraint bed with permanently attached straps in a prison we have visited visited by the NPM.

10 Directorate of Correctional Service (2002). Guidelines to the Execution of Sentences Act and its Regulations, section 38.7. Revised version of 15 March 2019.

Intrusive and detrimental to health

Being placed in a restraint bed is a major violation on personal integrity, and creates a risk of somatic injuries, trauma and other negative consequences to mental health.

Somatic risks include dehydration, circulation and skin problems, loss of muscle strength and mobility and incontinence. It also entails a risk of death as a result of blood clots.[11] Two fatalities have occurred during or after the use of restraints in mental healthcare institutions in Norway in the past 25 years: one as a result of a blood clot in 1998, and one due to cardiac arrest in 2011. In Denmark, a death was reported in 2016 as a result of a blood clot shortly after the use of a restraint bed in prison.[12]

We know that the use of restraints in mental healthcare institutions pose a risk of personal injury. Such injuries can occur during the initial phase of the application of the restraint, due to lack of supervision, the inmate being placed in the bed for an excessive amount of time, or other reasons, such as body parts being trapped prior to application of the restraint, or aggressive behaviour from staff. In an attempt to control the inmate, the staff may overreact, thus leading to heavy-handed and painful use of force.[13]

The person put in the restraint bed will react with fear and panic, which is normal in this situation as he or she may feel that they are fighting for their life. Aggressive reactions from staff can result in conduct that escalates the conflict and constitutes a greater risk of injuries.[14]

There is also a considerable risk of negative mental health consequences. Feelings of powerlessness, helplessness, loneliness, fear and re-traumatisation are reported. In addition to the immediate harmful effects, being put in a restraint bed can lead to negative long-term effects, such as traumatising memories, feelings of mistrust and symptoms of post-traumatic stress disorder.[15] Studies also show that experiences of harmful coercive events are made worse when there is a sense of miscommunication in the situation, such as the feeling of not being taken seriously, humiliated or being punished. Such negative experiences can last for several years after the event.[16, 17]

Because inmates are placed in restraints when they harm themselves or attempt suicide, there is reason to believe that there is an increased risk of such long-term effects. It can thus be concluded that inmates who are placed in restraint beds are subjected to an intervention that entails a clear risk of developing trauma in an acute life crisis.

11 Norwegian Official Report NOU 2019:14 (2019). Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven]. Oslo: Norwegian Government Security and Service Organisation, p. 267.

12 Ankerstjerne, (2018) Young man in restraint bed for 9 days in Vridsløselolle - died few days after release *[Ung mand lå fastspændt i 9 døgn i Vridsløselille - døde få dage efter],* TV2Lorry.no, 14. mars 2018. Available from: https://www.tv2lorry.dk/albertslund/ung-mand-la-fastspaendt-i-9-dogn-i-vridsloselille-dode-fa-dage-efter

13 Norwegian Official Report NOU 2019:14 (2019). Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven]. Oslo: Norwegian Government Security and Service Organisation, p. 265.

14 Norwegian Official Report NOU 2019:14 (2019). Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven]. Oslo: Norwegian Government Security and Service Organisation, p. 265.

15 Norwegian Official Report NOU 2019:14 (2019). Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven]. Oslo: Norwegian Government Security and Service Organisation, p. 267.

16 Norwegian Official Report NOU 2011:9 (2011). More self-determination and legal safeguards. Oslo: Norwegian Government Security and Service Organisation, p. 124.

17 Strout, T.D. (2010). Perspectives on the experience of being physically restrained: An integrative review of the qualitative literature. International journal of mental health nursing, 19, 416–427.

A restraint bed in a prison is demonstrated to the NPM.

Neither the Execution of Sentences Act nor the Regulations define a duty of supervision. The guidelines as amended in March 2019, now require continuous supervision by prison officers.[18] The Correctional Service's guidelines previously specified that prison officers needed to check on inmates placed in restraints at a minimum of once per hour.

Use of restraint beds in Norwegian prisons

Figures for the last six years (2013–2018)

There are currently 31 high-security prisons in Norway. Of these, 18 have a restraint bed.[19] None of the prisons have more than one restraint bed. The prisons have stated that restraint beds in the period 2013–2018 were used a total of 82 times for 51 persons. During that same period, the figures have varied between 8 and 20 times per year nationally. In the past two years (2017 and 2018), restraints have been used 15 and 13 times respectively.

18 Directorate of Correctional Service (2002). Guidelines to the Execution of Sentences Act and its Regulations, section 38.7. Revised version of 15 March 2019.

19 One of the prisons stated that it had an old restraint bed in the prison, but that the prison decided in 2016 to stop using it due to its age and standard. Another prison stated that its restraint bed is not approved, as is required, and has therefore never been used. The Directorate of Correctional Service has also stated that Arendal Prison, Evje Section, has ordered a new restraint bed.

A restraint bed in a prison is inspected by the NPM.

Of the 82 times restraint beds have been used, 27 cases concerned women, i.e. more than 30 per cent. During this period, the number of female inmates in Norwegian prisons has been approximately 6 per cent. It is not possible to conclusively establish the age of the persons placed in restraints, as the date of birth was lacking in 26 of the decisions we received.

Bredtveit Detention and Security Prison used the restraint bed 13 times in total during the period studied by the Parliamentary Ombudsman. Several cases concerned the same person. Bergen Prison used the restraint bed ten times in total for ten different people during this period. Åna Prison, Stavanger Prison and Tromsø Prison used the restraint bed nine times each during the period. At all three prisons, the restraint bed had been used several times for the same inmate. The rest of the prisons used the restraint bed between one and five times throughout the period, and only two prisons stated that they had not used the restraint bed at all, including one of the juvenile prisons where the restraint bed was not approved.

The longest time spent in a restraint bed was three days and 19.5 hours, while the second longest time was two and a half days. Inmates were placed in restraints for approximately 40 hours in several of the prisons, and in thirteen cases for more than 19 hours. Twelve cases lacked documentation of the duration of the use of the restraint bed.

Procedures in prisons

Of the 18 prisons with a restraint bed, 17 submitted their written procedures for the use of restraint beds. Of these, eleven prisons had not revised their procedures for the use of restraint beds since the Correctional Service's new guidelines to the Execution of Sentences Act entered into force in March 2019 (the prisons sent their procedures to us during July and August). Of the six prisons that had revised their internal procedures for the use of restraint beds, two had not updated the procedures in accordance with the new requirements for the information to be included in supervision logs.

Poor procedures are demonstrated by the fact that approx. ten per cent of the incidents involving inmates being placed in restraints appeared to take place without an administrative decision. It is also demonstrated by the fact that many of the prisons lacked important information in both the administrative decisions and the supervision logs. Some supervision logs lacked documentation over a period of several hours. This is discussed in more detail under the subtitle *Restraint beds and the prohibition against inhuman treatment*.

The role and procedures of the health service

Medical personnel must not be involved in decisions to use coercive measures, such as using restraint beds.[20] They are only responsible for safeguarding the patient's health and welfare in accordance with the 'primum non nocere' principle of preventing harm. The Nelson Mandela Rules set out detailed rules about the role of medical personnel in relation to persons deprived of their liberty who are placed in solitary confinement, isolation or subject to other similar interventions.[21] Medical personnel should ensure regular medical checks of the inmates' physical and mental health, and report adverse effects to health.[22] The Health Personnel Act Section 4 states that medical personnel must perform their work in accordance with the requirements of professional responsibility and diligent care. Medical personnel play a key role in relation to inmates placed in restraints, both because the decision is made on the grounds of self-harm and risk of suicide, and because being placed in restraints in itself poses a risk of injury.

Inadequate supervision and medical follow-up of the inmates' health while placed in restraint beds could be aspects of an evaluation that may result in a violation of Article 3 of the European Convention on Human Rights has taken place.[23]

The health risks posed by being placed in restraints means that a qualified and accessible health service with solid procedures for follow-up during and after the use of restraints is essential.

For medical personnel to attend to their duties according to the Health Personnel Act, they must have in-depth knowledge of the risk of harm caused by the use of restraints. Half of the health services in prisons that have a restraint bed do not have dedicated procedures for their role and tasks when inmates are placed in restraint beds. Most prisons are also dependent on assistance from the local accident and emergency unit for large parts of the day when the prison health service is closed. Very often, inmates are placed in restraint beds in the evening and remain restrained throughout the night. In practice, the accident and emergency unit is rarely contacted, even when an inmate is placed in a restraint bed.

A review of the supervision logs showed that, in about half of the cases, a doctor was not consulted in advance, or notified as soon as possible, as set out in the guidelines.[24] Several of the supervision logs revealed that inmates spent many hours in restraint beds without being supervised by medical personnel.[25]

Prison officers also reported that doctors from the accident and emergency units were not very aware of the risks associated with placing people in restraint beds. As a result the prison officers would wait until the next day to notify medical personnel when prison health service staff were available.[26] In the majority of the cases, the doctors from the accident and emergency units do not have previous knowledge of the patients.

20 The Mandela Rules, Rule 46 No 1.

21 The Mandela Rules, Rule 46 No 1, 2, 3.

22 The Mandela Rules, Rule 46 No 2.

23 Henaf v. France, application no. 65436, judgment of 27 November 2003, Section 47.

24 Directorate of Correctional Service (2002). Guidelines to the Execution of Sentences Act and its Regulations, section 38.7. Revised version of 15 March 2019.

25 See, *inter alia,* the Parliamentary Ombudsman's report after its visit to Åna Prison, 13–15 November 2017

26 CPT/Inf (93)12-part Health care services in prisons, section 75: 'Prison doctors and nurses should possess specialist knowledge enabling them to deal with the particular forms of prison pathology and adapt their treatment methods to the conditions imposed by detention.'

As example, we found a description in a decision that an inmate had repeatedly banged his head so hard against the floor in a police custody cell and subsequently in a security cell that he sustained visible head injuries. The inmate said that he wanted to die and asked to speak to a psychiatrist or a psychologist. Despite several telephone conversations with the accident and emergency unit, the doctor on call decided not to come and attend to the patient in question, but recommended over the phone to the corrections officer that the inmate be placed in a restraint bed. The accident and emergency unit did not follow up and attend to the patient while he was in restraints, despite being informed of the fact that he was vomiting due to his head injuries. In another case, an inmate with known and extensive trauma due to sexual abuse over many years, was placed in a restraint bed following an attempt to harm himself after being placed in a security cell. According to the administrative decision, the prison's health service believed there was a major risk to life and health, and efforts were made to transfer the inmate to the specialist health service. After the health service closed, the inmate was supervised by a doctor from the accident and emergency unit, who concluded that the inmate did not wish to be in prison. The doctor confirmed to the inmate that he would remain in restraints until further notice.

Our visits and review of documents have uncovered many weaknesses in the supervision provided by medical personnel. These are in contrast to the rules applicable to the mental healthcare service requiring continuous supervision by nursing staff when patients are placed in restraints.[27]

Most inmates are transferred to the restraint bed from a security cell, like this one.

A decision regarding the use of restraints in compulsory mental health care can only be made by a doctor who is an approved specialist, or a clinical psychologist with the relevant practice and further education set out in the regulations. The decision can be appealed to an oversight commission (called Control Commission) independent of the hospitals.[28]

The oversight commission must at its own initiative revise all decisions regarding restraints.[29] There is increasing recognition in the mental healthcare service that self-harm and suicidal tendencies should not be met with coercive measures such as restraint beds, as this increases the risk of coercion being used rather than reducing the behaviour one wishes to prevent.

The role of doctors in connection with decisions to use restraints must be limited to advising against using such measures if there are health reasons for doing so. Our review shows that there were several instances where medical personnel recommended using a restraint bed. In some cases, the medical personnel also stated that supervision by medical personnel was unnecessary as the prison staff carried out continuous supervision.

27 The Mental Health Care Act Section 4-8 fourth paragraph.

28 The Mental Health Care Act Section 4-8 fifth paragraph.

29 The Control commission's case processing, Circular, the Directorate of Health, 22 November 2016.

This attests to a lack of understanding of the role of medical personnel, and a lack of knowledge about the adverse health effects of restraint beds.

The supervision logs also showed examples of both prison officers and the prison's health personnel attempting to get inmates placed in restraints transferred to a mental healthcare institution, but that this was rejected by the specialist health service.

Restraint beds and the prohibition against inhuman treatment

The requirement of strict necessity

The ECtHR requires that the use of restraint belts must be necessary and proportional to prevent immediate harm.[30] According to Norwegian legislation, the use of restraints must only be employed when strictly necessary to prevent the inmate from hurting him or herself. The straps must be removed immediately when the risk of harm ceases. Less intrusive measures must always be attempted, unless it is obvious that they will have no effect.

We found a significant number of decisions regarding the use of restraint beds that lacked adequate reasons. Several decisions lacked an individual description of the specific situation that made the decision necessary. In some prisons, half of the decisions lacked reasons for the use of restraint beds. In total, around half of the eighteen prisons had one or several decisions that contained inadequate reasons. No administrative decision has been made in eight of the 82 cases concerning the use of restraint beds.

The lack of administrative decisions prevents the possibility for the inmate to file a complaint and limits appropriate internal control and oversight by external supervisory bodies. A lack of reasons for a decision also constitutes a threat to the legal safeguards of inmates.

The requirement of strict necessity applies to the entire restraint process. The ECtHR has established a violation of Article 3 in a case where an inmate, who was described as calm, was not released from the restraint bed.[31] This requirement has been violated in a significant number of cases where restraint beds have been used in Norwegian prisons during the past six years.

In two of the prisons, inmates were described as calm for most of the time spent in the restraint bed, in all the decisions made. In one prison, this applied to half of the decisions, while in other prisons this applied to several of the decisions.

During many of the incidents involving the use of a restraint bed, the inmates slept in the restraint bed. The Parliamentary Ombudsman has in several reports following visits to mental healthcare institutions criticised the fact that patients were asleep while in restraints, as patients who are asleep no longer constitute a situation where the requirement of 'strict necessity' is fulfilled.[32]

In some cases, the straps were loosened to let the inmate use the bathroom, make a call or shower, before being strapped back into the restraint bed. In these situations, an explanation was not provided for why the person should be placed in restraints again.

30 Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012.

31 Julin v. Estonia, application no. 16563/08, judgment of 29 May 2012.

32 See, inter alia, the Parliamentary Ombudsman's report after visits to Østfold Hospital, psychiatric unit on 9–11 October 2018, Stavanger University Hospital, 9–12 January 2017 and Akershus University Hospital, emergency psychiatry department, 2–4 May 2017.

Most of the decisions lacked documentation that other less intrusive measures had been attempted before using the restraint bed. The supervision logs showed that most of the inmates were transferred to a restraint bed from a security cell. A security cell is an intrusive isolation and sensory deprivation measure. The Parliamentary Ombudsman has in several instances expressed great concern over the fact that people who are suicidal are placed in solitary confinement in security cells.[33] There is reason for concern that the use of security cells in reality can contribute to creating a situation that results in an inmate being placed in a restraint bed.

Duration

The ECtHR has in several judgments stated that the risk of a violation of Article 3 increases the longer a person is placed in restraints.[34] In a decision from 2009, the Court found that a violation of Article 3 had taken place in a case where a person had been placed in a restraint bed for 10 hours.[35] In a decision from 2012, the ECtHR found a violation of Article 3 in a case concerning a person being placed in a restraint bed for 9 hours. ECtHR stated the following:

"Confinement to a restraint bed, […] should rarely need to be applied for more than a few hours […]"

and

"Having regard to the great distress and physical discomfort that the prolonged immobilisation must have caused to the applicant, the Court finds that the level of suffering and humiliation endured by him cannot be considered compatible with Article 3 standards".[36]

Almost half (39) of the incidents concerning the use of restraint beds lasted for longer than ten hours. A significant number of these cases (13) lasted for longer than 19 hours. The supervision logs for 12 of the cases regarding the use of restraint beds did not contain information about the duration of these measures. The figures may therefore be even higher. In most of the cases, neither the decision nor the supervision logs provide any documentation as to why it was necessary to use the restraints for so long.

Supervision

Supervision is vital to preventing harm in these situations, and for ensuring a continuous assessment of whether the measure remains necessary. In its ruling from 2012, the ECtHR stated that one of the conditions that must be present in order to use a restraint bed is that checks are periodically carried out.[37]

Since 2019, the guidelines pertaining to the Execution of Sentences Act have outlined a requirement for continuous supervision in the event of the use of a restraint bed. The requirement was previously that supervision had to be conducted at least once per hour.

Many of the supervision logs showed more frequent supervision. Although most of the prisons underlined that continuous supervision was their established practice, this was not documented in the supervision logs.

During the Parliamentary Ombudsman's visits, we have learned that staff at some prisons are instructed to limit conversation with inmates placed in restraint beds. The reason for this is the idea that limiting human contact would ensure

33 Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons, Report 4:3 (2018/19).

34 Julin v. Estonia, application no. 16563/08, judgment of 29 May 2012, Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012, M.S. v. Croatia (no. 2, application no. 75450/12), judgment of 19 May 2015.

35 Wiktorko v. Poland, application no. 14612/02, judgment of 31 March 2009.

36 Julin v. Estonia, application no. 16563/08, judgment of 29 May 2012.

37 Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012.

that the restraint bed does not become more attractive to inmates than the security cell. In one prison, the restraint bed was placed in a way that prevented the person in restraints from seeing whether anyone was keeping an eye on them. Such circumstances can reinforce the feeling of being powerless and isolated when the inmate is already subject to a highly intrusive measure.

Several of the prisons' supervision logs lacked information that could document whether and when medical personnel had seen the inmate.

Inmates with mental illness

The ECtHR ruling from 2012 pointed out that people with mental illness are particularly vulnerable, and that this must be considered when determining whether Article 3 has been violated.[38]

We know from Norwegian studies that inmates in general have a high rate of mental illnesses.[39] When inmates are put in a restraint bed in order to prevent self-harm, this produces a clear risk of additional trauma and worsening of their mental health.

The UN Special Rapporteur on Torture points out that 'any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment'.[40]

One of the supervisory logs stated that the 'inmate had childhood traumas concerning restraint beds'. The inmate was nonetheless placed in a restraint bed. In another decision concerning restraint beds, it emerged that the person placed in restraints had been declared unfit to serve the sentence, due to extensive trauma after serious sexual abuse in their youth.

Other conditions that increase the risk of violations

Clothing

Very few supervision logs contained clear information about the inmate's clothing. The wording in several of the supervision logs suggested that inmates had been naked in the restraint bed. It has also emerged several times during the NPM's visits that inmates have been placed naked in restraint beds.

When placed in restraints, people are denied the possibility to defend themselves, and are therefore particularly vulnerable to abuse and inhuman treatment. Not wearing clothes in such situations increases this risk. It also reinforces the feeling of vulnerability and increases the risk of negative psychological effects as a consequence of being placed in restraints.

The revised guidelines have incorporated a requirement that the person placed in restraints must be clothed or his or her body must be covered. However, the new guidelines do not state that a person placed in restraints should never be naked.

In one of the supervision logs, an inmate was described as being restrained in a restraint bed without a tunic, even though she wanted to wear one. According to the supervision log, the inmate was told that personnel from the healthcare department would speak to her first. There were four members of staff in the room at the time, of whom at least three were men. No documentation showed that the inmate was covered by a blanket. The decision to give her a tunic was not made until one hour later. Other supervision logs also indicated that inmates were placed naked in restraint beds, in some instances with, and in other instances without, a blanket.

38 Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012, paragraphs 85 and 88.

39 Cramer, V. (2014). Forekomst av psykiske lidelser hos domfelte i norske fengsler. Oslo: Oslo University Hospital.

40 See the UN Special Rapporteur on Torture Juan Mendez's report to the UN Human Rights Council 1 February 2013, A/HRC/22/53, pages 14–15, section 63 and page 23, section 89 b).

Being strapped naked to a restraint bed with prison officers of the opposite sex in the same room, can be a very humiliating experience and increase the risk of trauma. It is important to underline that this can apply to inmates of both sexes.

Gender

Gender is a point of vulnerability. The UN Rules for the Treatment of Women Prisoners and Non-Custodial Sanctions for Women Offenders (the Bangkok Rules) underline the importance of good policies and regulations for staff working with female inmates.[41]

We know that many female inmates have been the victims of abuse and different forms of sexual exploitation.[42, 43] These are factors that can exacerbate the sense of humiliation from being placed in restraints. Over 30% of cases of inmates being placed in restraints in the period concerned women. This included some of the longest periods spent in restraints.

Additionally, the decisions analysed showed that female inmates who had been put in restraint beds, more often had been restrained several times, compared to male inmates who had been put in restraint beds. Five of the seven inmates who had been put in restraint beds four times or more, were women.

Language

A lack of opportunity to communicate with those the inmate depend on, is also a point of vulnerability. Foreign inmates are entitled to information in a language they understand.[44] The prison must ensure that the inmate has understood the grounds for the decision and understands the information that is provided. One of the supervision logs showed that the prison did not call an interpreter, although the inmate in the restraint bed requested an interpreter.

Juvenile inmates

The threshold for placing juvenile inmates in restraint beds is higher than for adults – it must be 'absolutely necessary'. In one instance, a juvenile inmate remained strapped to, and at times, asleep in, the restraint bed for over 13 hours without medical supervision. This incident is mentioned in one of the Parliamentary Ombudsman's visit reports.[45] A review of the prison's procedures on the use of restraint beds also showed that they did not include separate points on the use of restraint beds in cases regarding juvenile inmates.

Summary and Recommendation

The use of restraints in prison in order to prevent inmates from harming themselves or attempting suicide, raises important human rights and health-related questions. The revision of 82 decisions, alongside experience and the data collected from visits to several prisons, identified the following main issues:

Risk to life and health

The use of restraints involves a risk of both somatic injuries, including fatal injuries, as well as a risk of trauma and serious psychological distress. Despite this, in most of the cases where restraint beds were used, they were used with minimal supervision by medical personnel. Qualified medical personnel are generally neither present at the start of nor during the time spent in restraints.

41 The UN Rules for the Treatment of Women Prisoners and Non-Custodial Sanctions for Women Offenders (the Bangkok Rules), adopted by the UN General Assembly on 21 December 2010, A/RES/65/229.

42 Directorate of Norwegian Correctional Service (2015). Likeverdige forhold for kvinner og menn under kriminalomsorgens ansvar.

43 Report No 37 to the Storting (2007-2008). Punishment that works – less crime – a safer society.

44 The UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), adopted by the UN General Assembly on 17 December 2015, Rule 61 No 2. The recommendation of the Council of Europe's Committee of Ministers, Rec (2006) 2 to the member states about the European prison rules (The European Prison Rules), principle 38.3.

45 The Parliamentary Ombudsman's report after its visit to Bergen Prison 2–4 May 2018.

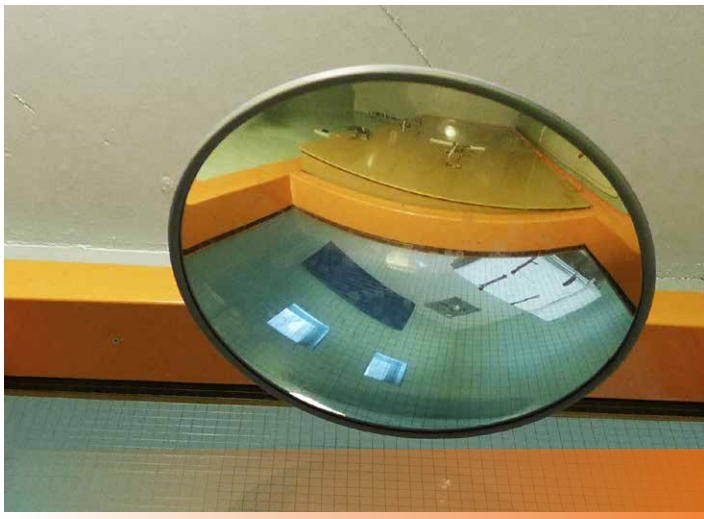
Inmates placed in restraints do not receive medical assistance from the specialist health service, but from the local accident and emergency unit or from the prison health service. Doctors from the accident and emergency unit do not have expertise in the use of restraints, and the review of the prison health service's procedures revealed major shortcomings.

On a national level, restraint beds were only used on an average of 15 times per year. This entails a risk that prison officers with little or no previous experience with restraints must use this highly intrusive measure on inmates in acute psychological crisis.

Discrimination

The use of restraints to prevent people from harming themselves is a contentious issue. The UN Special Rapporteur against Torture has stated that persons with mental illnesses should not be subjected to such forms of coercion. The Parliamentary Ombudsman has in several visit reports and in the Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons, pointed out that solitary confinement in prison can increase the risk of suicide, self-harm and development of serious mental disorders.[46] Several of the cases where restraint beds were used seemed to result from precisely such a sequence of events; where suicidal inmates had been placed in solitary confinement and started to self-harm in the security cell.

People who are suicidal or have inflicted serious self-harm need medical assistance. If restraint beds in practice become a measure that prevents inmates from getting the medical assistance they require, the use of restraint beds can constitute discrimination and a violation of the inmates' right to receive medical assistance.



View into a cell equipped with a restraint bed through a surveillance mirror over the door to the cell.

The fact that women are at a higher risk of being placed in restraints than men, and that they are more often put in restraints several times, raises additional questions about discrimination.

Lack of legal safeguards

Although the use of restraint beds is one of the most intrusive measures a prison can use, the quality of the decisions and supervision logs show significant shortcomings in the legal safeguards for those concerned. A large number of decisions do not explain why the measure was deemed strictly necessary, or document why the decision should be upheld, and there is no documentation stating that less intrusive measures have been attempted. These extensive shortcomings prevent a real possibility to file a complaint and raise major issues in relation to internal oversight. Many of the factors indicate a violation of the prohibition against inhuman treatment, set out in the UN Convention against Torture and the ECtHR Article 3 as interpreted by the European Court of Human Rights.

Based on these factors, the Parliamentary Ombudsman considers there to be a high risk of inhuman treatment in connection with the use of restraint beds and recommends that restraint beds be discontinued in prisons.

46 Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons (Document 4:3 (2018/2019), pp. 66–67.

Special Report on Solitary Confinement in Norwegian Prisons

In June 2019, the Parliamentary Ombudsman submitted a Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons. The report is based on findings from the National Preventive Mechanism's (NPM) visits to 19 Norwegian prisons over the course of four years. The nature of these findings were so grave that we chose to compile them in a separate Special Report to the Storting – the most powerful instrument available to the Parliamentary Ombudsman.

Background for the Special Report

For several years, Norwegian authorities have been criticised internationally for their use of solitary confinement in prisons. As recently as in 2018, the UN Committee against Torture expressed great concern about the extent of prolonged solitary confinement, and that the conditions for use of solitary confinement were not sufficiently clear. In the same year, the European Committee for the Prevention of Torture (CPT) visited Norway and recommended in its report that inmates held in solitary confinement in Norway should be offered structured activities and have meaningful human contact on a daily basis. The committee was particularly concerned about the solitary confinement of inmates with mental health problems.

During the period 2014–2018, the Parliamentary Ombudsman's National Preventive Mechanism (NPM) has carried out 20 visits to 19 high-security prisons. The overall findings paint a serious picture of the use of solitary confinement in Norwegian prisons.

The Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons was submitted to the Storting on 18 June this year.

The purpose of the report was to make the Storting aware of the risk of inhuman or degrading treatment represented by the use of solitary confinement in prisons.

Solitary confinement in Norwegian prisons – inadequate regulation and overview

The key element of solitary confinement is that the inmate is separated from other inmates, and that meaningful human contact is reduced to a minimum. Internationally, there are several different definitions of the term solitary confinement. All these definitions are based on the premise that solitary confinement is a measure that is serious, intrusive and detrimental to health.

The UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) prohibits confinement for 22 hours or more a day without meaningful human contact for more than 15 consecutive days. The Special Report to the Storting underlines that Norwegian legislation does not provide for such a limitation in time. In our neighbouring countries Denmark and Sweden, there are rules in place that specify that inmates must not be locked up for longer than 12 hours a day. In Norway, it is up to the individual prison sections to determine when inmates are let out of their cells in the morning and locked in the evening. In several prisons, we have observed that inmates placed in what is known as a communal section are, in reality, locked inside their cells for 22 hours a day or longer. The lack of clear statutory or regulatory requirements on how much time inmates should be entitled to spend associating with other inmates, creates ambiguity and diminishes the authorities' knowledge of the extent of solitary confinement in Norwegian prisons.

Extensive solitary confinement and restrictions on association with other inmates

In the report, the Parliamentary Ombudsman points out that there are major weaknesses in the authorities' control of the use of solitary confinement in Norwegian prisons. Our collection and review of figures show that there is no reliable overview of the extent of solitary confinement in Norwegian prisons. This means that the responsible authorities lack necessary information to assess measures to reduce the use of solitary confinement and limit its harmful effects.

A minimum estimate based on the Correctional Service's own figures show that one in four inmates in Norwegian prisons is locked in their own cell for 16 or more hours a day. The figure is higher during weekends. After the publication of the Special Report, the Directorate of Correctional Service has pointed out that the figures are, in all probability, even higher. This runs counter to the European Committee for the Prevention of Torture's (CPT) recommendation that all inmates are entitled to at least eight hours of meaningful activity outside their cell every day.

One of the most disturbing findings from the NPM's prison visits is that the most extensive use of solitary confinement is not due to the conduct of the inmate, but to financial or practical challenges within the prison organisation. At times, over half of all instances of solitary confinement in Norwegian prisons have been due to a lack of available activities, low staffing levels or a lack of common areas in the sections.

Some findings also indicate that the number of inmates who choose to be in solitary confinement is increasing. This type of solitary confinement usually happens because of a general sense of insecurity, mental health challenges or because the inmate is afraid of other inmates. The prison staff

present play a crucial role in creating a sense of security and identifying inmates who withdraw from the company of others and from daily activities.

Harmful effects of solitary confinement

The report presents a wealth of documentation available about the physical and mental health effects of solitary confinement. Contact with other people is one of the most fundamental human needs, and research confirms that a high proportion of those in solitary confinement experience some form of physical or mental health issue as a result of the solitary confinement.[1] The harmful effects of solitary confinement can be immediate, but the number of inmates who develop health problems and the severity of such problems increase with the length of confinement.

The most effective way of reducing the harmful effects of solitary confinement is to facilitate meaningful human contact. The most effective measure will always be to ensure that inmates have the opportunity to spend time with others for most of the day.

In cases where this is not feasible, it is imperative that the prison ensures that inmates have contact with people in other ways, such as contact with staff, external parties such as prison visitors, or other inmates when possible. During the NPM's visits to prisons, inmates frequently tell us that prison officers rarely find the time to have long and meaningful conversations with them, and that the only contact they have with staff is in connection with daily tasks, such as handing out meals and medication. On the other hand, the prison officers often point out that they do not have time to focus on individual inmates in solitary confinement and that the staffing levels are too low. There is a lack of common guidelines and training on how to safeguard inmates to limit the detrimental effects of solitary confinement.

People who already have mental health issues or a mental disability are particularly vulnerable to the harmful effects of solitary confinement.

Inadequate follow-up from the health service

International standards state that medical personnel must visit inmates in solitary confinement every day. There is no such minimum requirement in Norwegian legislation, and the Directorate of Health recommends that medical personnel visit inmates when medical reasons so indicate. This is not sufficient because it means inmates are dependent on the assistance of prison staff to get in touch with the health service. We have found examples in several prisons where the health service was not contacted or notified, despite documentation showing that inmates had repeatedly requested the assistance of medical personnel. There are multiple cases where several days passed between visits from medical personnel, despite the inmate in question displaying major and obvious mental anguish or reported physical injuries.

The report also makes reference to an absence of statutes and central guidelines that ensure that medical personnel follow up inmates in solitary confinement in a responsible manner.

Our visits have also uncovered a clear lack of competence among medical personnel regarding the harmful effects of solitary confinement and a lack of adequate follow-up and measures to prevent such effects.

1 See, inter alia: Shalev, S. (2008). A Sourcebook on Solitary Confinement. London: Mannheim Centre for Criminology, London School of Economics.
Smith, P. S. (2006). The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature. Crime and Justice, 34, 476-487.
Howard, F. F. (2018). The effect of segregation. Prison Service Journal, 236, 4-11.
Smith, P. S. (2008). Solitary confinement. An introduction to the Istanbul Statement on the Use and Effects of Solitary Confinement. Torture Journal, 18, 56-62

The NPM organised a panel discussion on solitary confinement in Norwegian prisons during the Arendalsuka event.

Solitary confinement in security cells

The report also focuses on the most intrusive form of solitary confinement in Norwegian prisons: the use of security cells. During our visits, we have found that the physical conditions in security cells in several prisons have been deplorable. With the exception of a mattress on the floor, security cells are completely bare. The size of several such cells was below the international minimum standard.[2] Food is slid onto the floor through a hatch, which, in many instances, is situated near the squat toilet. There is little or no possibility of looking out of many of the security cells. Some cells are fully lit 24/7. This seriously undermines the inmate's possibility of sleep and their notion of time. Such sensory deprivation attests to alarmingly low levels of knowledge about the risks of solitary confinement.

Our findings show that security cells are often used for people experiencing a personal crisis or severe mental crisis with a risk of suicide or self-harm. Many of the staff in a number of prisons have shown that they do not have the capacity to deal with people in crisis in any other way than using security cells. This is the opposite of what people in acute life crises need – namely to be in touch with empathetic people who listen. Findings have also shown that staff lack training and safe procedures for how to follow up inmates in security cells, both to prevent the detrimental effects of solitary confinement and to ensure that no inmates are placed there longer than the law allows for such an intrusive measure.

2 After its visit to Norway in 2018, the CPT stated that cells measuring less than six square metres must only be used for a few hours at a time.

Follow-up and consideration of the Special Report

The Special Report on Solitary Confinement and Lack of Human Contact in Norwegian Prisons will be considered by the Storting during the spring of 2020. On 26 November 2019, the Parliamentary Ombudsman presented the findings and recommendations of the report to the Standing Committee on Justice as part of the preparations for the consideration in Parliament.

After the submission of the Special Report in June 2019, the Parliamentary Ombudsman has worked systematically to ensure that the report's findings and recommendations are known and followed up by the responsible authorities. Meetings have been held with the heads of the Ministry of Justice and Public Security, the Ministry of Health and Care Services, the Directorate of Correctional Service and the Directorate of Health. Meetings have also been held with the Correctional Service trade unions, Wayback – Foundation for the Rehabilitation of Prisoners, the Organisation for Families and Friends of Prisoners, the Norwegian Medical Association and the Norwegian Nurses' Association. The organisations that are members of our advisory committee are also kept up to date about the process. The report was also presented to a broader audience at a special event during Arendalsuka in August 2019, which was streamed on our website.

The Special Report to the Storting has been translated into English and shared with relevant international stakeholders.

10 recommendations from the Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons

1. Ensure reliable and publicly available data on the extent of solitary confinement in Norwegian prisons.

2. Establish a national standard to ensure that inmates have the possibility of associating with others for at least eight hours every day and are offered meaningful activities.

3. Amend the provisions of the Execution of Sentences Act to ensure that:

   - solitary confinement is only used in exceptional cases and for as brief a period as possible;
   - follow-up off all inmates in solitary confinement in accordance with human rights standards;
   - solitary confinement for 22 hours or more a day is prohibited in situations mentioned in the Nelson Mandela Rules.

4. Submit a proposal for a statutory or regulatory duty to prevent the use of solitary confinement in prisons.

5. Strengthen the Correctional Service's supervisory regime by defining a legal mandate that ensures systematic and regular supervision in accordance with international human rights standards.

6. Ensure that common professional guidelines are drawn up to ensure satisfactory follow-up of inmates in solitary confinement.

7. Prepare a plan for closing down or adapting all prison sections currently not adapted for association between inmates.

8. Revise the national guidelines to health and care services for prison inmates, to ensure that the detrimental effects of isolation are identified and that inmates in solitary confinement receive follow-up.

9. Establish by law that the health service is responsible for following up inmates in solitary confinement, so that inmates who are isolated or excluded from company are followed up by medical personnel on a daily basis.

10. Ensure that the prison health services are provided with a stronger common professional platform, with particular focus on competence relating to inmates' special health issues, solitary confinement and the detrimental effects of isolation.

Consultation Submissions as Part of the Preventive Work

Legislation in accordance with human rights standards is a pre-condition for preventing torture and inhuman treatment of people deprived of their liberty. This year, we have made several consultation submissions on draft legislation proposals and other guidelines from central government authorities, which affect the conditions for people who have been deprived of their liberty and who are subjected to coercion.

Consultation submissions are an important measure to ensure adequate legislative processes and strong legal safeguards for people who have been deprived of their liberty. Our consultation submissions are based on findings and experiences from the visits we have conducted under the national prevention mandate to date. In 2019, we submitted four consultations covering several sectors under the NPM mandate.

Inadequate evaluation of rules on the use of coercion in child welfare institutions

The Parliamentary Ombudsman made a consultation submission in July on the then Ministry of Children and Equality's draft of a new Child Welfare Act.[1] Our comments concerned the proposal to create further legislation for child welfare institutions.

We pointed out that it was generally positive that the draft legislation proposal clarified the rights children and young persons have during stays in institutions. However, we called for a more detailed assessment of the proposals on children's rights and the use of coercion in light of Norway's human rights obligations.

We recommended that the Ministry undertake a new assessment of the current regulation regarding rights and the use of coercion in child welfare institutions.[2] The assessment should be based on Norway's human rights obligations, with reference to international legal developments. It should also be assessed whether the existing regulations are practised as intended.

We also pointed out that the current rules on the use of coercion are not always complied with in practice, which indicated a need for clarification of the legislation. Findings from our visits indicate that lack of compliance may be due to misinterpretations of the regulations.

1 The Parliamentary Ombudsman's consultation submission on the draft new child welfare act, 22 July 2019. Read the whole consultation submission here: *https://www.sivilombudsmannen.no/wp-content/uploads/2019/07/Sivilombudsmannens-h%C3%B8ringsuttalelse-om-forslag-til-ny-barnevernlov.pdf*

2 Regulation on the Rights of Children in Institutionalized Childcare (Rights Regulation).

In addition, we also made comments to the specific proposal. For instance, the Parliamentary Ombudsman emphasised the following problematic elements in the proposal:

- **the existing provision on the prohibition against isolation used as punishment, treatment or as a corrective measure is to be removed**
- **the prohibition against coercion used as punishment, treatment or as a corrective measure is to be limited to 'physical' coercion, even if improper psychological pressure and threats can cause equally serious harm**
- **the regulations on the use of coercion in situations of acute danger refer to ambiguous rules based on the principle of necessity that is not included in the child welfare legislation**
- **the draft legislation proposal contains no minimum requirement for the use of isolation in situations of acute danger**
- **the legal limits for restricting children's freedom of movement inside and outside an institution are not clearly defined, including what constitutes illegal isolation**

A so-called "isolation room" at a child welfare institution visited by the NPM. The room was taken out of use after our visit.

Important guidelines for detainees in need of medical help

In September, we made a consultation submission on the Directorate of Health's proposal for national guidelines for medical personnel relating to health services for detainees in police custody.[3]

Several of the recommendations made by the National Preventive Mechanism (NPM) after visits to police custody facilities, are reflected in the draft guidelines. The draft emphasises that doctors must not be involved in decisions concerning placing a person in custody. The submission also proposes measures to ensure that the duty of confidentiality is maintained when medical assistance is given to detainees, by ensuring that police personnel who escort the detainee are not present during examinations and treatment situations, for instance in the accident and emergency unit.

3 The Parliamentary Ombudsman's consultation submission on guidelines for medical services for detainees in police custody, 29 August 2019. Read the whole consultation submission here: *https://www.sivilombudsmannen.no/wp-content/uploads/2019/09/Sivilombudsmannens-h%C3%B8ringsuttalelse-om-veileder-om-helsetjenester-til-arrestanter-i-politiarrest.pdf*

The Parliamentary Ombudsman emphasised that the proposal lacks national procedures for documentation and reporting cases of suspicion of disproportionate use of force or injury to the detainee caused by the police. One of the recurring findings from the NPM's visits to places of detention, including police custody facilities, is that there is a lack of procedures in place for what medical personnel should do in cases of suspicion of disproportionate use of force or injuries caused by the police. Several of the accident and emergency units visited lacked a system to ensure that injuries to detainees were adequately documented in patient records, including photographic ocumentation. None of the accident and emergency units visited had any procedures in place for situations where it was suspected that injuries to a detainee was caused by the police.

In the consultation submission, we emphasised that documentation and reporting of injuries inflicted on persons deprived of their liberty are important legal protections and can reduce the risk of torture and inhuman treatment. We referred to the European Committee for the Prevention of Torture (CPT), which recommends that thorough health examinations are carried out with documentation of suspicious injuries, and that such injuries are quickly reported in order to protect the detainees and ensure that an investigation is launched. Such procedures are lacking in Norway.

We also asked that medical personnel be given more information regarding the harmful effects of isolation and how the health of persons in isolation should be followed up.

The photo shows a spit hood of the type that is used by Norwegian police. The Ministry has not stated what type of spit hood it proposes for use by the Correctional Service. Photo: Ruben Skarsvåg.

Critical to the proposal to use spit hoods in prisons

In September, we made a consultation submission regarding the Ministry of Justice and Public Security's proposal to amend the Execution of Sentences Act's rules on coercive measures.[4] One of the proposals involved introducing the use of spit hoods to the list of legal coercive measures. Another proposal involved lowering the threshold for using coercive measures such as handcuffs and body cuffs.

A spit hood is a transparent hood that is pulled down over the head of the detainee, which covers the lower part of the face and prevents the person from spitting. In our consultation submission we noted that the Ministry had failed to consider that the use of spit hoods also entails the use of other restraints, such as hand cuffs or body cuffs, to prevent the detainee from removing the spit hood.

According to the Ministry, the basis for the proposal was the increasing problem of detainees spitting. However, no information was presented that demonstrated that this was a growing trend. The Ministry stated that spitting can entail a risk of infection, without outlining the type of infection referred to, or how great the risk is.

4 The Parliamentary Ombudsman's consultation submission on proposed amendments to the Execution of Sentences Act (use of spit hoods), 30 September 2019. Read the whole consultation submission here: *https://www.sivilombudsmannen.no/wp-content/uploads/2019/10/Sivilombudsmannens-h%C3%B8ringsuttalelse-om-forslag-til-endringer-i-straffegjennomf%C3%B8ringsloven-bruk-av-spytthette-mv..pdf*

The Ministry suggested that the spit hood could be used on inmates placed in common areas while socializing with others, as a measure to prevent solitary confinement. The Parliamentary Ombudsman pointed out that it is unlikely that more meaningful human contact can take place if inmates are wearing a spit hood in addition to mechanical restraints such as handcuffs or body cuffs while interacting with other inmates. This can have a humiliating and dehumanising effect on the inmates and constitutes a clear risk of inhuman and degrading treatment.

We also criticised the Ministry's failure to explain the risks linked to using a spit hood. An EU regulation on controlling the trade in items that can be used to inflict torture or inhuman treatment show that spit hoods pose a risk of asphyxiation. Several cases have been reported in other countries where people have died while wearing spit hoods, and where disproportionate use appears to have contributed to or caused the death.

We emphasised that having a hood pulled down over one's head can contribute to a strong sense of fear, high levels of stress, a feeling of loss of control and a sensation of being choked. This particularly applies to people with serious conditions, such as psychosis, anxiety and phobias, such as claustrophobia. This is a particular cause for concern given that a high proportion of the inmates in Norwegian prisons have serious mental health issues, to a much greater extent than the rest of the population in general.

In addition to spit hoods, the Ministry also proposed lowering the threshold for the use of restraints such as hand cuffs and body cuffs. The Parliamentary Ombudsman disagrees with the Ministry that these restraints are less intrusive. A body cuff can restrict the inmates' freedom of movement to the extent that they cannot walk or move their arms. The fact that the use of a spit hood entails both a hood and a mechanical restraint being placed on the inmate, indicates that this is a highly intrusive coercive measure.

We also expressed concern that the purpose of the proposed amendments was to prevent inmates being confined to their cells because it did not seem advisable to let the person spend time in common areas without wearing restraints. The Ministry's proposal is inadequate for addressing the challenges of solitary confinement. The proposal to introduce the use of spit hoods and to lower the threshold for using other restraints indicate that a more integrated approach is necessary for creating prison conditions that prevent the need to use such intrusive measures. The Parliamentary Ombudsman pointed out that implementing measures to counteract the high degree of solitary confinement in prisons is now of urgent importance.

The segregation unit in a mental healthcare ward.

Input to proposal on common rules on use of coercion in the health and care services

In December, the Ombudsman made a consultation submission on the Østenstad Committee's draft legislation proposal on the use of coercion and interventions without consent in the health and care services (Norwegian Official Report 2019: 14 *Tvangsbegrensningsloven*).[5] The comments were based on the Ombudsman's statements in complaints cases and findings from visits to places of detention under the mandate of the NPM.

In the consultation submission, the Ombudsman called for a more detailed assessment of the threshold for applying involuntary treatment, such as forced medication and electroconvulsive therapy (ECT) in relation to human rights standards. Such questions were not sufficiently addressed in the report, particularly in light of international legal developments resulting in more stringent control of the use of coercive measures concerning persons with disabilities.

The Ombudsman pointed out that the legislation must ensure adequate protection against torture and other inhuman or degrading treatment. The legislation must also be in accordance with the prohibition against discrimination based on disabilities and the right to protection of personal integrity and self-determination. The Ombudsman stated that the legislator is obligated to undertake a general proportionality assessment of new legislation that authorises such use of force.

The Committee proposed to uphold the practice of forced medication. It is the opinion of the Ombudsman that the report did not substantiate a fair balance between the benefits such an intervention has and the harm it inflicts. This was specifically based on the lack of adequate knowledge of the effects of these treatment measures and the serious nature of such interventions. The Ombudsman also criticised the Committee's proposal to legalise ECT without informed consent as a life-saving measure.

5 The Parliamentary Ombudsman's consultation response to Norwegian Official Report 2019: 14 Tvangsbegrensningsloven, 30 December 2019. Read the whole consultation submission here: *https://www.sivilombudsmannen.no/wp-content/uploads/2019/12/Sivilombudsmannens-høringssvar-NOU-2019_14-Tvangsbegrensningsloven.pdf*

The Ombudsman was critical of the fact that inadequate research meant that it remained unclear whether ECT is necessary to save lives, or whether other measures could prove just as effective.

In more general terms, the Ombudsman also called for the proposed draft legislation to clarify that any person deprived of their liberty still has fundamental rights. The Ombudsman also pointed out that the law is construed in a complex manner, making it difficult to understand both for the individual patient or user and for medical and care personnel. There is therefore a need to ensure that the legislation is written in a more accessible language.

The Ombudsman expressed concern over the Committee's proposal that measures are only to be considered coercive if the patient shows resistance. The background for this concern is that many patients do not show resistance due to trauma, or because an unequal balance of power makes resistance seem futile. The Ombudsman was furthermore critical of the Committee's proposal to make a lack of decision-making competence a key requirement for the use of coercion. This is problematic for reasons such as it being unclear how such assessments should be done and which criteria it should be based on.

The Committee also proposed rules on the use of force in emergency situations, including legally establishing health law rules for grounds of necessity and self-defence, and strengthening the rules on particularly intrusive measures to prevent injury in emergency situations. The Committee's proposal to phase out mechanical restraints within three years will, in the Ombudsman's view, help to reduce the risk of inhuman or degrading treatment. Even so, the Ombudsman recommended that immediate measures be considered to ensure that the use of mechanical constraints on children ceased as quickly as possible.

The Ombudsman also called for special legal safeguards to prevent long-term use of mechanical restraints. We also pointed out that it was doubtful whether the Committee's proposal to allow segregation to prevent injury (isolation) in order to prevent damage to property is in accordance with human rights standards. The Ombudsman was also critical of the Committee's proposal to limit the list of particularly intrusive measures to include only the act of being held to the ground by force, and not other intrusive forms of manual coercion.

With respect to segregation, we noted that several of the Committee's proposals reflected findings from the Ombudsman's visits. The Ombudsman noted that more stringent rules applied to the option of using segregation as a treatment measure, but that the proposal to lower the threshold for use of segregation out of consideration to others constituted a risk of more widespread use. Furthermore, the Ombudsman called for clearer guidelines on the practice of segregation, including setting limits for the use of force or for maintaining segregation. The Ombudsman also called for assessments of special legal safeguards to prevent prolonged segregation, including limiting the allowed duration of segregation decisions.

The Ombudsman also made several other comments on topics such as, the proposal to introduce a duty to prevent the use of coercion, the right to limit visits and telephone use, use of house rules and procedural rules.


4

First Five Years – Some Results

As a National Preventive Mechanism (NPM), our goal is to influence and contribute to change beyond the individual institutions we visit. We want our reports and recommendations to contribute to improved legal safeguards and protection against inhuman treatment at every institution in Norway where people may be deprived of their liberty.

Introduction

In the period from 2014 to 2019, we have carried out 65 visits. The reports from our visits, and the follow-up of the recommendations that we make, are published on our website and shared through social media. Many of our findings and recommendations are followed up by the individual places we visit. Several findings have also contributed to changes at a national level.

This chapter describes some of the systemic changes the Parliamentary Ombudsman has contributed to in its first five years as a National Preventive Mechanism (NPM).

The follow-up of the *Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons* is discussed in a separate article in Chapter three.

4 NYHETER Onsdag 27. november 2019 FREDRIKSSTAD BLAD

FREDRIKSSTAD BLAD Onsdag 27. nov

Sykehuset fjernet belter fra psykiatri-senger etter kritikk:

– Det var også i strid med egne prosedyrer

Sivilombudsmannen kritiserte sykehuset for høy tvangsbruk i deler av psykiatrien. Nå er belter fjernet fra senger, og alle rutiner skal gjennomgås grundig.

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- Vi synes det har vært veldig fint at vi fikk et eksternt, solid blikk inn i virksomheten vår, sier Irene Dahl Andersen, klinikksjef for psykisk helsevern og rusbehandling ved Sykehuset Østfold.

- Noe av det som ble påpekt, burde vi ha avdekket selv, erkjenner hun.

I april offentliggjorde Sivilombudsmannen to rapporter om tvangsbruk i tre enheter innen psykiatrien på sykehuset; sikkerhetsseksjon 1 og 2, samt alderspsykiatrisk seksjon.

Det ble blant annet fastslått at beltebruken var hyppigere og mer omfattende enn på andre tilsvarende sikkerhetspsykiatriske avdelingsenheter.

De fleste pasientene er dømt til behandling. De er innlagt fordi de har en fatlighetsproblematikk og har behov for særlig beskyttelse, har Dahl Andersen forklart i et tidligere intervju.

- For dårlige rutiner

Noe av kritikken handlet om at skjermingsrommene hadde senger med ferdig monterte remmer til belter.

- Dette sender et uheldig signal og er lite trygghetsskapende for pasientene, mente sivilombudsmannen.

Dahl Andersen forteller at de påmonterte beltene var i strid med deres egne prosedyrer, og at dette var noe av det de selv burde hatt kontroll på. Beltene er nå fjernet, som ett av flere strakstiltak i kjølvannet av rapportene.

- Vi hadde prosedyrer på at beltene ikke skulle være synlige på sengene, men det ble dessverre ikke fulgt. Vi hadde for dårlige rutiner, sier hun.

Kan ikke bare ta mobilen

Et annet strakstiltak har vært å gjøre skjermingsrommene hyggeligere, med gardiner og farger.

Sykehuset har også endret formuleringer i husordensreglene, blant annet en regel om at de ansatte kunne frata pasientene mobiltelefonen. Sivilombudsmannen påpekte at innskrenkning i pasientenes kontakt med andre ikke måtte være i strid med loven.

- Å frata telefon på generelt grunnlag er lovbrudd. Man må fatte et eget vedtak med begrunnelse for å kunne ta fra noen telefonen. Dette har vi nå rydded opp i, sier Irene Dahl Andersen.

Sivilombudsmannen ba i tillegg sykehuset om å sikre at alle pasienter får tilbud om samtale etter tvangsbruk, om hvordan de opplevde det. Det er nå på plass, ifølge klinikksjefen.

Tvangsmidler kan være fastholding, beltebruk, medisinering og skjerming. All bruk av tvang er nedfelt i lovverket.

Nye forslag til forbedringer

Dahl Andersen understreker imidlertid at det viktigste som er kommet ut av Sivilombudsmannens rapporter, er en fullstendig gjennomgang av alle rutiner ved alle seksjoner. En arbeidsgruppe legger fortløpende frem forslag til forbedringstiltak.

- Vi er i full gang med et omfattende arbeid for å se på bruken av tvang. Vi har blant annet fått bedre statistikk over tvangsbruk, noe som var mangelfullt på grunn av datasystemet, sier Dahl Andersen.

- Sivilombudsmannen mente at vi hadde for dårlig oppfølging og oversikt på et overordnet nivå, og det hadde de jo rett i.

- Hva med kritikken mot for mye tvang? Hvordan skal dere få ned tvangsbruken?

- Jeg er usikker på om det vi arbeider med, gir en reduksjon. Tiltakene bidrar først og fremst til en kvalitetssikring og forhåpentligvis en mer skånsom bruk av tvang, svarer Irene Dahl Andersen.

Pasientene avgjør

Han understreker at målet er størst mulig grad av frivillighet, altså at pasientene vil legges inn og motta behandling.

- Men det avhenger jo av pasientens tilstand. Vi kan ikke sette et måltall på tvangsbruk, fremholder Dahl Andersen.

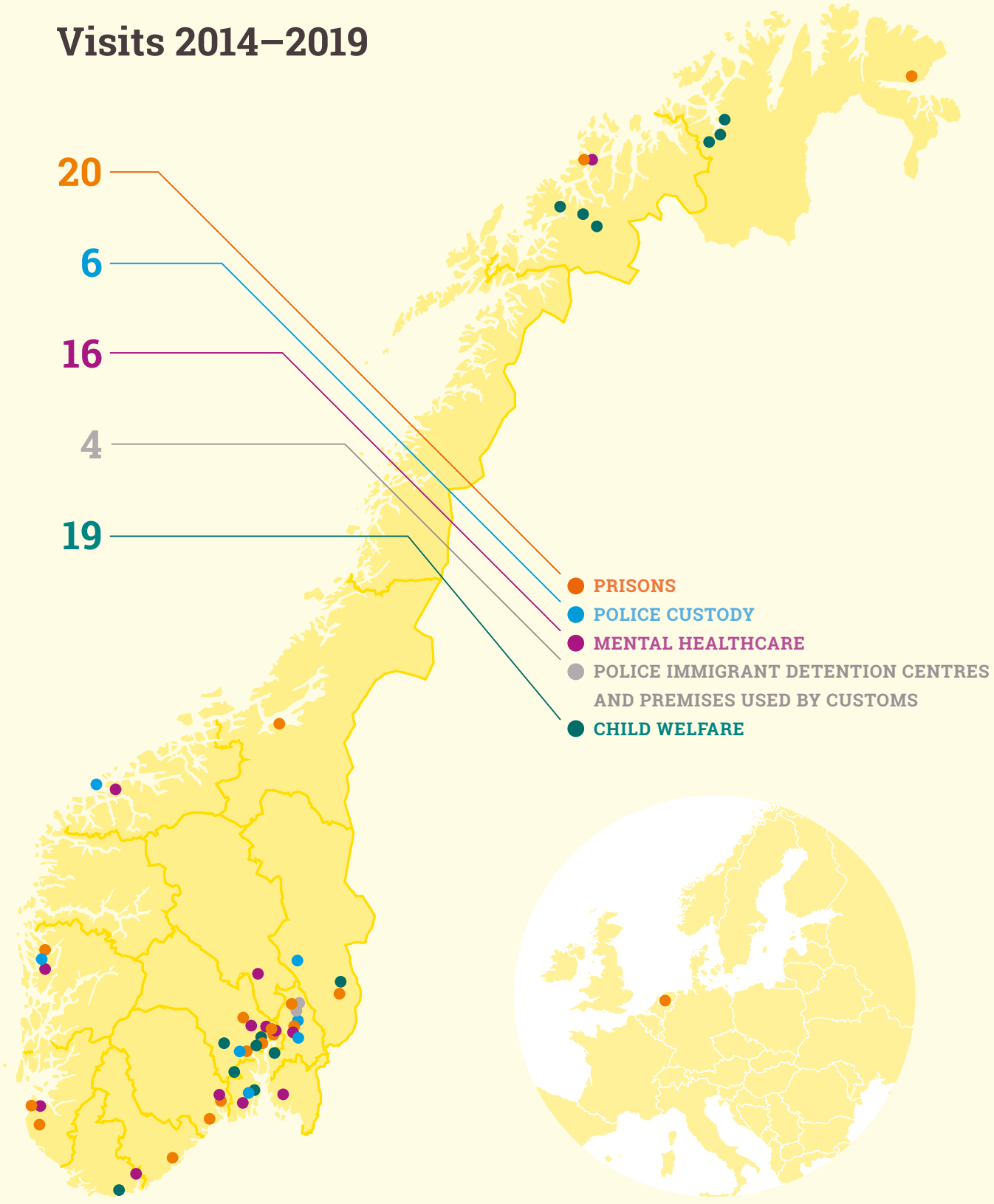
- Hvis vi får inn pasienter som er svært dårlige og til fare for seg selv og andre, kan vi ikke si til de ansatte at de ikke kan bruke flere tvangsmidler fordi det ikke er i overensstemmelse med et eventuelt mål som vi har satt oss. Men vi skal gjøre det riktig og så skånsomt som mulig. Vi skal gi forsvarlig behandling og helsehjelp.

SYKEHUSET ØSTFOLD KALNES

NYE TILTAK: *Sykehuset Østfold og klinikksjef for psykisk helsevern, Irene Dahl Andersen (innfelt), har måttet endre rutiner etter kritikk fra Sivilombudsmannen.*

The NPM criticised the hospital for its extended use of coercion in its psychiatric ward. As a result of the comments from the NPM, the hospital removed the restraint beds from the ward and will evaluate its internal routines regarding the use of coercion. Facsimile from Fredrikstad Blad.

Visits 2014–2019



2014

PRISONS

Bergen Prison

Tromsø Prison

POLICE CUSTODY

Drammen Police Custody

Tønsberg Police Custody

2015

PRISONS

Bjørgvin Prison's Juvenile Unit

Kongsvinger Prison

Ringerike Prison

Telemark Prison, Skien Branch

Trondheim Prison

POLICE CUSTODY

Lillestrøm Police Custody

Ålesund Police Custody

POLICE IMMIGRANT DETENTION CENTRES AND PREMISES USED BY CUSTOMS

Trandum Immigration Detention Centre

Places of detention at Gardermoen

MENTAL HEALTHCARE

Diakonhjemmet Hospital

Sørlandet Hospital, Kristiansand

Telemark Hospital

2016

PRISONS

Bredtveit Detention and Security Prison

Drammen Prison

Norgerhaven Prison

Stavanger Prison

Telemark Prison

Vadsø Prison

POLICE CUSTODY

Bergen Police Custody

MENTAL HEALTHCARE

Akershus University Hospital, Adolescent Psychiatric Clinic

University Hospital of Northern Norway Health Trust (UNN)

CHILD WELFARE

Akershus Youth and Family Centre, Sole Department

The Child Welfare Service's Emergency Institution for Young People

2017

PRISONS

Ila Detention and Security Prison

Ullersmo Prison

Ullersmo Prison, Juvenile Unit East

Åna Prison

POLICE IMMIGRANT DETENTION CENTRES AND PREMISES USED BY CUSTOMS

Trandum Immigration Detention Centre

MENTAL HEALTHCARE

Akershus University Hospital, Emergency Psychiatric Department

Oslo University Hopital, Psychosis Treatment Unit, Gaustad

Stavanger University Hospital's Special Unit for Adults

Ålesund Hospital, Psychiatry Department

CHILD WELFARE

Aleris Alta

Alta Youth Centre

Hedmark Youth and Family Centre

The Klokkergården Collective

2018

PRISONS

Arendal Prison

Bergen Prison

Oslo Prison

MENTAL HEALTHCARE

Reinsvoll Psychiatric Hospital

The County Psychiatric Department, Vestfold Hospital

Østfold Hospital, Secure Psychiatric Sections and Geriatric Psychiatric Section

CHILD WELFARE

Agder Institution for Adolescents, Furuly department

Kvammen Emergency Institution

The Skjerfheim Collective

2019

MENTAL HEALTHCARE

Stavanger University Hospital, Child and Adolescent Psychiatry Units

CHILD WELFARE

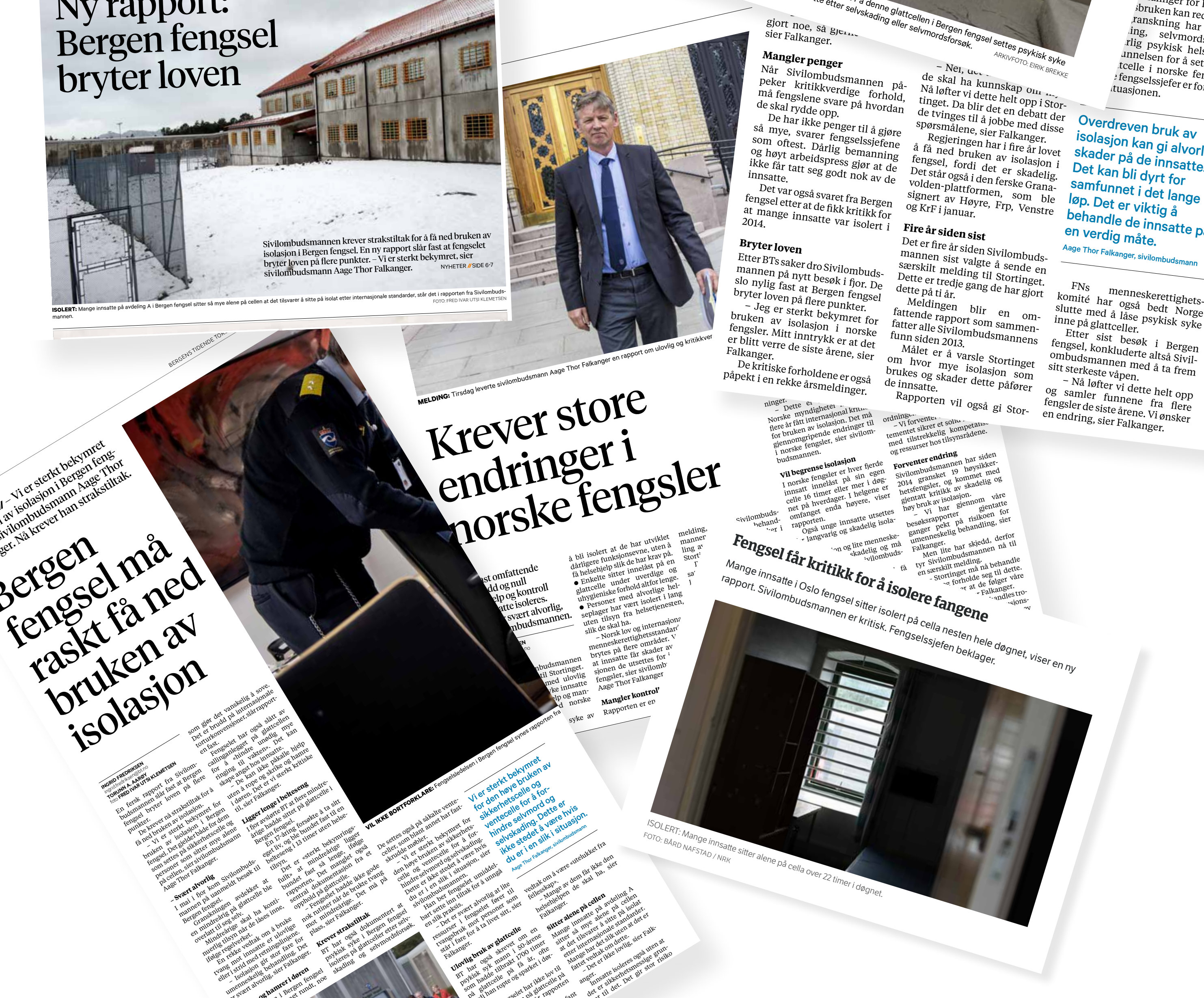
Buskerud and Vestfold Emergency Youth Centre, Barkåker

Humana Child Welfare Service East

Jong Youth Centre

Stendi Region North

There has been great media interest in the NPM's work. Sources: Bergens Tidende and NRK



Mental healthcare – improved legal safeguards in mental health care facilities

Strengthening the legal safeguards of those subjected to coercion during treatment is an important objective in our work on the mental healthcare sector. This applies to all forms of coercion, including when coercion forms part of the treatment plan. Since 2015, the NPM has carried out 15 visits to mental healthcare institutions.

New expectations of the oversight commissions

In 2016, the Norwegian Directorate of Health sent a letter to all oversight commissions in Norway (the Control Commissions) based on the findings and recommendations from our visits.[1] The Norwegian Directorate of Health made it clear that the patient and next-of-kin are to receive a decision in writing as soon as possible with adequate reasons explaining the decision. It was also emphasised that patients and next-of-kin were to be informed in writing about their right to appeal and other general rights, by posting notices and making other written information available. Furthermore, it was specified that patients must be informed when the Control Commission is visiting the hospital. The importance of keeping a written log of when restraints and segregation is used was also highlighted. These clarifications have now been added to the Norwegian Directorate of Health's annotations.[2]

The Norwegian Directorate of Health has continued to follow up our work and shares our findings and recommendations to the country's Control Commissions. Every year, the Parliamentary Ombudsman is invited to present new findings after visits to mental healthcare institutions at the national conference for all the Control Commissions in Norway.

More stringent requirements to the use of coercion

Invasive coercive measures such as use of restraint beds and segregation require that adequate reasons are provided in order to ensure that patients are not subjected to unnecessary or disproportionate use of coercion. We have found it necessary to emphasise this issue in several of our reports. The practice of the Supreme Court indicates that the threshold for the adequacy of reasons is higher the more invasive the coercive measure is. Particular importance is placed on clarity and transparency, and it must be possible for the person subjected to coercion to understand why the legal requirements are met. The duty to provide adequate reasons is intended to ensure thoroughness and precision on the part of the decision-makers and is an important part of an individual's legal safeguards. Inadequate administrative decisions undermine the patients' opportunity to appeal and reduces oversight bodies' opportunity to perform their control functions.

We have been particularly critical of institutions' decisions on the use of segregation and treatment without the consent of the patient.[3] In connection with the amendments to the law that entered into force in September 2017, more stringent requirements were adopted for reasons for decisions regarding treatment without the consent of the patient. The new Mental Health Care Regulations Section 4–4a specified requirements that already followed from the Public Administration Act and the Mental Healthcare Act. The detailed requirements for written reasons correspond with the requirements for the assessments that have to be made by those responsible for the decision before treatment without the consent of the patient can be performed.[4]

1 Letter from the Norwegian Directorate of Health to the supervisory committees dated 27 September 2016: 'Clarification of legislation following the Parliamentary Ombudsman's visit reports during the period 2015/2016.'

2 Circular Mental Health Care Act with annotations, Section 1–1, last paragraph.

3 See also the Parliamentary Ombudsman's statements regarding treatment without the consent of the patient (forced medication), case no. 2017/543, 2017/3156 and 2018/2278.

4 Proposition No 147 L. (2015-2016), page 39.

A balcony for patients in a psychiatric hospital ward.

Following the amendments to the law, DIPS – the largest supplier of electronic patient records in the specialist health service – introduced new templates for administrative decisions for e.g. treatment without the consent of the patient and segregation. The specifications in the regulations and changes in the templates are in line with the observations made by the Ombudsman concerning the conditions at several hospitals and are important for the patients' legal safeguards.

More rigorous oversight of electroconvulsive therapy (ECT) used on grounds of necessity

During all visits to hospitals in 2017 and 2018, we examined the use of electroconvulsive therapy (ECT) on the basis of necessity. As ECT therapy is considered to be a serious intervention, it is illegal to administer it without the patient's informed consent.[5] In some hospitals, ECT is nonetheless sometimes administered without the patient's consent, with reference to the provision on the principle of necessity of the Penal Code. This entails that there must be a danger to the life and health of the patient that cannot be averted in 'any other reasonable manner'.[6]

We found that the hospitals had very different practices for using ECT based on the principle of necessity. We also found some examples of use that were clearly not in line with the principle of necessity.

The Norwegian Directorate of Health subsequently implemented several measures to strengthen legal safeguards and supervision of the use of ECT based on the principle of necessity. There is a high threshold for situations that could warrant the use of ECT based on the principle of necessity, which was specified in the new guidelines published in 2017.[7] In addition, in 2018 the oversight commissions (called Control Commissions) were tasked with supervising the institutions' decisions on initiating ECT on grounds of necessity.[8] Although the principle of necessity would still be very problematic as a basis for such an intrusive treatment against the patient's will, these measures have contributed to improving the possibilities of oversight.

The difference between means of restraint and segregation

It has been necessary to point out in several of the visit reports that segregation[9] is not a restraint measure, and that the threshold and conditions for using restraint measures and segregation are different. During our visits, we have seen manual restraints being used on several occasions – without a separate administrative decision being made – as a means of initiating and maintaining the segregation of a patient. For instance, several hospitals have employed a practice where patients are taken by force or carried to the segregation unit or their room, as part of a segregation decision.

5 The Patient and User Rights Act Section 4-1 and the Mental Health Care Act Section 4-4 second paragraph.

6 The General Civil Penal Code Section 7. See also the ministry's preparatory works to the Mental Health Act regarding use of ECT warranted by the principle of necessity, Proposition No 11 (1998–1999) to the Odelsting page 108–109.

7 The Directorate of Health (June 2017): National guidelines for the use of electroconvulsive therapy (ECT), page 26–28.

8 The Directorate of Health's letter to the supervisory commissions in mental healthcare, 'Behov for styrket kontroll med bruk av elektrokonvulsiv behandling (ECT) uten samtykke' (The need to improve control measures regarding the use of electro-convulsive treatment (ECT) without consent), 17 April 2018. See also the Directorate of Health's comments to the Mental Health Care Act S. 4-4 second paragraph, where our findings and assessments are highlighted.

9 Segregration in this context describes a particular form of open area seclusion used in Norway, where patients are segregated from other patients but have healthcare personnel present in the area. The measure is referred to as 'shielding' in Norwegian legislation and may be imposed for up to 14 days at a time.

This is a breach of the duty to make an individual administrative decision for intrusive measures such as manual restraint, and it will in many instances be a breach of the conditions required by law for using restraints. In a separate thematic report on segregation, we emphasised this issue in addition to several other problematic findings concerning hospitals' use of segregation.[10] The Directorate of Health has now specified that it is not allowed to use manual restraint to initiate or maintain the segregation of a patient, apart from gentle physical leading.[11]

New draft legislation on the use of coercion in the health and care services

A new draft legislation proposal on the use of coercion in the health and care sector was presented in June 2019.[12] The Committee responsible for drafting the proposal referred several times to the Parliamentary Ombudsman's preventive work, in particular with regard to the use of segregation. [13,14] In our thematic report on segregation in mental healthcare institutions, we concluded that the current use of segregation constitutes a risk of inhuman treatment.[15] The Committee finds that the current legal regulation of segregation is unsatisfactory. The Committee proposes raising the threshold for segregation as a form of treatment, for instance by ensuring that the legal requirements are the same as for other forced treatment.

Our reports on degrading conditions in many of the segregated units also appear to have influenced the Committee, which specifies that segregation rooms should be furnished in the same way as an ordinary patient rooms, if reasonable in relation to individual risk assessments.

In several reports, we have pointed out that restraint beds should not be placed in segregation units. They create a sense of insecurity among the patients, and easy access to them can increase the risk of restraint beds being used. The Committee recommends phasing out the use of mechanical restraints over the course of a three-year period after the law has entered into force,[16] and that, in the meantime, 'mechanical devices should not be kept in the vicinity of the ward in question when not being actively used'.[17]

A room in a segregation unit in a psychiatric hospital ward visited by the NPM.

10 For a more detailed description of segregation, see the thematic report 'Skjerming i psykisk helsevern – risiko for umenneskelig behandling' ('Segregation in mental healthcare – risk of inhuman treatment' – in Norwegian only), 2018.

11 Circular Mental Health Care Regulations with annotations, Section 18, fifth paragraph.

12 *Tvangsbegrensingsloven*. Proposal for common rules on the use of coercion and intervention without consent in the health and care sector. Norwegian Official Report 2019:14.

13 Norwegian Official Report NOU 2019:14 Chapter 6: Experience of using the sets of rules, sub-chapter 6.2.5. *The Parliamentary Ombudsman's National Preventive Mechanism*. Our annual reports and thematic reports on segregation in mental healthcare institutions are summarised here.

14 Norwegian Official Report 2019:14. Sub-chapter 25.6.3.2 *Criticism of the use of segregation.*

15 Thematic report on segregation in mental healthcare – risk of inhuman treatment (2018), see sub-chapter 8.7 *Segregation and human rights.*

16 Draft legislation Section 4–3 third paragraph.

17 Draft legislation Section 4-4 third paragraph.

Child welfare service – increasing the legal safeguards for children and young persons in institutionalized childcare

In 2016, the NPM started visiting child welfare institutions. We have visited 19 such institutions so far. Visits have been made to a variety of places; small, large, state-owned, non-profit and commercial institutions. A recurring theme during the visits has been the routine and unlawful use of coercion and restrictions. Following a visit report that uncovered serious use of routine and unlawful coercion,[18] the Directorate for Children, Youth and Family Affairs (Bufdir) reported on its website that it would review all of Norway's emergency institutions to ensure compliance with the Regulation on the Rights of Children in Institutionalized Childcare (Rights Regulation).[19]

Improved supervision of child welfare institutions

A good dialogue with the oversight authorities is vital to ensuring expedient prevention work at the national level. It is the county governor's responsibility to oversee child welfare institutions. During 2017 and 2018, we were invited on several occasions to give talks to county governors about our methods and our findings and recommendations from visits to child welfare institutions. Through dialogue with several county governors, we also get the impression that our reports are actively used in their oversight work.

The Norwegian Board of Health Supervision has overall responsibility for the county governors' oversight of the child welfare institutions.[20] The Norwegian Board of Health Supervision can make direct requirements of the county governors with respect to the methods they use, oversight themes and priorities. One of the Norwegian Board of Health Supervision's main priorities in 2018 was the oversight of child welfare institutions.[21] The NPM was invited by the Norwegian Board of Health Supervision to describe our methodology, as well as our findings and recommendations following visits to institutions in the child welfare sector. The Norwegian Board of Health Supervision pointed out in its 2018 annual report that it had identified failings in the oversight of child welfare institutions, and concluded that too few violations of the law are probably identified in the county governors' supervision, although the number of violations highlighted had increased in the past year. The findings from our visits were highlighted as the basis for strengthening the county governors' oversight of child welfare institutions.

18 The Parliamentary Ombudsman's report after its visit to Kvammen emergency institution, 16–17 January 2018.

19 *https://www.bufdir.no/Aktuelt/Arkiv/2018/Alvorlige_avvik_pa_barnevernsinstitusjon/* (retrieved 22 November 2019).

20 The Child Welfare Act Section 2–3b first paragraph.

21 The Norwegian Board of Health Supervision's annual report 2018.

'Motivational trips' as a therapeutic method must be on a voluntary basis

The Norwegian Board of Health Supervision asked Bufdir to interpret the practice of involuntary 'motivational trips' as a therapeutic method as part of the treatment at child welfare institutions.[22] Such a 'motivational trip' could for instance mean that an adolescent is taken to a remote house or a cabin outside the institution's area, together with two members of staff over a period of several days.

The background for wanting an interpretative statement was the Parliamentary Ombudsman's report and follow-up after a visit to a treatment institution for adolescents with substance abuse problems in 2017. In this report we pointed out that the Rights Regulations does not allow for adolescents to be taken on 'motivational trips', neither as part of the treatment plan, nor as punishment or by use of coercion.[23] We also emphasised that these trips were not conducive to a sense of security among the adolescents.

The adolescents usually did not know how long a trip would last, and they were not always told the reason for being taken away from the institution alone.

The Norwegian Board of Health Supervision agreed with the Parliamentary Ombudsman's assessment, and emphasised the importance of ensuring that the county governors, Bufetat's approval authorities and the institutions have the same understanding of the rules about when and how freedom of movement can be restricted.

In March of 2019, Bufdir pointed out that motivational trips must be based on the consent of the residents.[24] They concluded that keeping adolescents in premises located outside the institution area is not permitted. The Parliamentary Ombudsman is aware that several institutions have carried out such involuntary 'motivational trips'. Bufdir's clarification that this is not in accordance with the Rights Regulation is therefore important for the safety and legal safeguards of adolescents in child welfare institustions.

Contribution to national police custody regulations

The Parliamentary Ombudsman's NPM has since 2014 visited several police custody facilities where people have been brought in for disturbing the peace or on suspicion of criminal activity. Several findings and recommendations from these visits have also contributed to changes at a national level.

New regulations for use of police custody

The lack of a common national regulatory framework for the use of police custody was previously a major challenge. The consequence was that every single police district created local instructions for how the custody facilities should be run, and how the rights of the detainees should be respected. This constituted a risk to the legal safeguards and welfare of detainees.

22 The Norwegian Board of Health Supervision reference 2018/1674 1 HAK.

23 Letter from the Parliamentary Ombudsman to Klokkegårdenkollektivet of 25 April 2018, available on our website: https://www.sivilombudsmannen.no/besoksrapporter/klokkegardenkollektivet/#filer

24 The Norwegian Directorate for Children, Youth and Family Affairs (Bufdir), 31 March 2019. Interpretative statement – use of involuntary trips as therapeutic method as part of treatment in child welfare institutions. Reference 2018/55424-3.

The NPM visiting a police custody cell.

In March 2016, the National Police Directorate presented a proposal for a common national regulatory framework to be used by all police custody facilities. The Parliamentary Ombudsman commented on the directorate's proposal in a consultation submission in April 2016, and subsequently on the directorate's revised proposal in May 2018.[25, 26] In November 2018, the National Police Directorate adopted the new national custody instructions with instructions explaining the rules in more detail.[27] Many of our recommendations from visits to police custody facilities are reflected in the new instructions.

According to the new instructions, all cells should have a clock, colour contrast between the floor and walls, adequate lighting, a sufficient amount of daylight and the possibility to dim the lights at night. The instructions stipulate important legal safeguards about the right to notify next-of-kin and contact a lawyer, and the right to contact a doctor when medical assistance is required. The detainees must also be informed of their rights in a language they understand, if necessary through an interpreter. They have a right to be given information in writing. We pay particular attention to these factors during our visits to police custody facilities.

The custody instructions also include an important recommendation from the Parliamentary Ombudsman that body searches that include the removal of clothing cannot take place without an individual risk assessment. Should a body search be carried out, it must take place in a manner that ensures that the detainee is not fully naked.

After our comments, new and more stringent rules have been introduced regarding placing several detainees in the same cell. The instructions also provide exhaustive rules on the use of coercive measures, such as hand cuffs in custody facilities and measures to safeguard the detainees' health and safety when coercive measures are used.

Both the Courts and the Ombudsman have criticised the use of solitary confinement in police custody facilities that is not strictly necessary. Detainees are henceforth entitled to associate with others to avoid solitary confinement. The police have a duty to assess whether there is a real need to use solitary confinement, and to implement measures to prevent solitary confinement and counteract harmful effects in instances where solitary confinement has been strictly necessary.

In accordance with the Parliamentary Ombudsman's recommendations, the instructions also contain rules for detainees' right to medical assistance. When detainees are taken to the doctor, they should be able to speak directly and unsupervised to medical personnel, without police listening in on the conversation. The police must not be present in, or able to look into, the patient room, unless the medical personnel specifically request this or there is a risk of escape. Important clarifications have also been introduced to make it clear that the role of medical personnel in such instances is to provide healthcare, not 'clearance for remand in custody'.

25 The Parliamentary Ombudsman's consultation submission – proposal for national custody instructions, 20 April 2016.

26 The Parliamentary Ombudsman's comment on a revised draft of the national custody instructions, 31 May 2018.

27 The National Police Directorate, Instructions for the use of police custody facilities (the Custody Instructions), Circular 2018/011, 9 November 2018 and Instructions for the use of police custody facilities, case no. 2016/00772 (same date).

New guidelines on health services for detainees

In 2019, the Directorate of Health presented a draft guideline for medical personnel on how the right to health care should be addressed in police custody. The guideline has been created in collaboration with the National Police Directorate, and describes how the detainees' rights as patients should be safeguarded during the deprivation of liberty.

The draft included the Parliamentary Ombudsman's recommendations in the field, among others that doctors must not be involved in approving whether someone is placed in custody, and that the police escorting detainees must not be present during medical examination and treatment, for instance at accident and emergency units.

Migrant detention centres – Families with children no longer detained at Trandum

The Parliamentary Ombudsman's NPM has visited the Police Immigration Detention Centre at Trandum twice since 2014. We conducted an unannounced visit to the detention centre in May 2015, and carried out a new unannounced visit to the detention centre's security section in March 2017.

In our report following the first visit, we raised concern about the practice at Trandum at the time of detaining children – both unaccompanied children and children detained with their families. In the report, we pointed out that the detention centre did not appear to be a suitable place for children. Although there were no children at the detention centre at the time of our visit, we stated that the environment was marked by stress and unrest, including sizeable riots and incidents such as smashing furniture, self-harm, suicide attempts and use of force. This was not deemed to be a satisfactory psychosocial environment for children.

The following year, the European Court of Human Rights rendered five judgements against France regarding the violation of the European Convention on Human Rights (ECHR) in cases concerning the detention of families with children in immigration cases.[28] In May 2017, Norway was found guilty of breach of the ECHR by a Norwegian court in a similar case concerning the detention of a foreign family with children under 15 years.[29] The Court ruled that the detention of children in this case constituted a breach of Article 3 of the ECHR on the prohibition against torture, inhuman or degrading treatment or punishment.

The development of the law in the field and the Parliamentary Ombudsman's visit reports contributed to increased pressure from organisations such as Norway's National Human Rights Institution (NIM), the Ombudsman for Children, the Norwegian Bar Association and the Norwegian Organisation for Asylum Seekers (NOAS) to find solutions to prevent children being placed in the immigration detention centre.

28 ECtHR ruling 12 July 2016 A.B and others v. France, application no. 11593/12; ECtHR ruling 12 July 2016 R.M and others v France, application no. 33201/11; ECtHR 12 July 2016 R.C. and V.C. v France application no. 76491/14; ECtHR ruling 12 July 2016 A.M and others v France, application no. 56324/13; ECtHR ruling 12 July 2016 R.K and others v France, application no. 68264/14.

29 Borgarting Court of Appeal, 31 May 2017, LB-2016-8370.

The National Police Immigration Service (NPIS) established a family unit at Haraldvangen in Hurdal municipality in December 2017. According to NPIS, the family unit has a civilian feel and the staff do not wear uniforms. It is a closed detention centre, meaning that windows and doors are locked. Even so, the detainees are free to move around inside the building.

The development since 2015 suggests that the situation for children detained on immigration control grounds has improved somewhat, in that children are ensured an environment better suited to their vulnerability. This development shows that the change required to prevent human rights violations often requires the involvement of multiple parties and pressure over time. The Parliamentary Ombudsman has yet to visit the family unit.

In 2015, the Parliamentary Ombudsman criticised the practice of detaining children and their families at Trandum Immigrant Detention Centre, where this photo was taken. Children and their families are now detained in a separate family unit in Haraldvangen.

Increased focus on preventing solitary confinement in prison

Since 2014, the Parliamentary Ombudsman has visited a high proportion of the high-security prisons in Norway. We have visited all the high-security prisons for inmates in preventive detention, women and minors. We have also visited the country's only prison section with a particularly high level of security.

In our experience, the Directorate of Correctional Service has kept well informed of each prison's measures to follow up our recommendations.

Our findings and recommendations were, already from 2015, referred to in the Ministry's management of the Correctional Service's priorities. The Ministry of Justice and Public Security's allocation letter for 2019 states:

"*The Directorate of Correctional Service must, as far as possible, ensure that the recommendations of the Parliamentary Ombudsman and the National Preventive Mechanism against torture and inhuman treatment in connection with deprivation of liberty is followed up in an adequate manner. Violations of human rights must be investigated. We ask the directorate to comment on particularly important observations and recommendations made by the Parliamentary Ombudsman and the National Preventive Mechanism, and on planned and implemented measures to meet the recommendations set out in the 2019 annual report.*" [30]

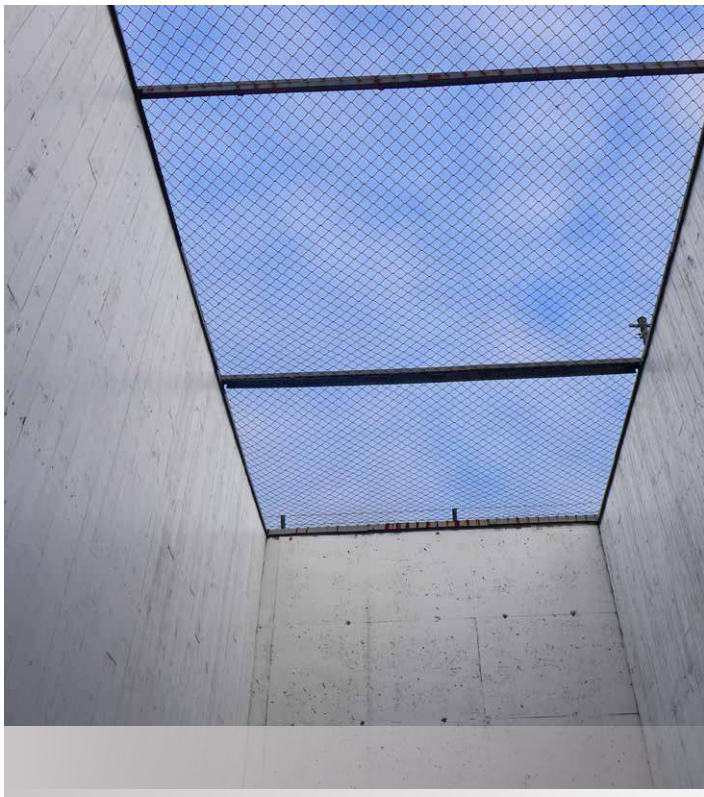
30 The Ministry of Justice and Public Security, allocation letter to the Directorate of Correctional Service, 18 January 2019, page 17.

This is also reflected in the Directorate of Correctional Service's management of the prison regions and the individual prisons. For instance, the Directorate receives the prisons' draft replies on follow-up of our visit reports and provides comments to the individual prisons before the follow-up letters are sent to us. The directorate has also sent letters on several occasions specifying the regulations to all prisons as a response to our findings.[31]

Solitary confinement and restrictions on association with other inmates

Already during our first visits to prisons in 2014, the Parliamentary Ombudsman found inmates who were confined to their cells for most of the day, and who had little opportunity to associate with others. A continued focus on this issue over the years has helped put this problem on the agenda.

Early on, we criticised the prisons' inadequate overview of the extent of exclusion from common areas, in addition to lack of clear legal definitions and a lack of relevant statistics.[32] As follow-up of the Parliamentary Ombudsman's findings and recommendations, the Correctional Service began, in 2015, to count the number of inmates who spent less than eight hours outside their cells. Together with the random day counts of the number of inmates who spent less than two hours outside their cells that was initiated in 2012, this produced a more comprehensive picture of the challenges facing the Correctional Service regarding solitary confinement and restrictions on association with other inmates.



View from an 'open air cell' in a prison visited by the NPM. These cells are used as exercise yards for inmates in solitary confinement.

In August 2016, the Correctional Service proposed amendments to the guidelines to the provisions of the Execution of Sentences Act regarding exclusion and association with other inmates. The proposed amendments included important clarifications, including the requirement for an administrative decision to be made for exclusion from common areas to ensure a better overview of the scope. In our consultation submission, we pointed out that these changes were not sufficient.[33] The background for this was that human rights standards had introduced more stringent requirements for the use of solitary confinement, and we therefore considered it important that the Execution of Sentences Act' statutory provisions were assessed in light of this change.

31 See, for example, Directorate of the Norwegian Correctional Service, *Dagsmålinger og manglende vedtak om utelukkelser*, letter of 8 April 2015 to the correctional service regions.

32 The Parliamentary Ombudsman's report after its visit to Bergen Prison 4–6 November 2014, p. 13.

33 The Parliamentary Ombudsman's consultation response to the guidelines on exclusion pursuant to Section 37 of the Execution of Sentences Act, 1 November 2016.

The guidelines were amended, but a comprehensive assessment of the legislation was not initiated by the Ministry, as we had recommended. During subsequent visits, we found that the extensive use of solitary confinement in prisons increasingly posed a risk of inhuman and degrading treatment. After repeatedly raising these issues with key health and justice authorities, the Ombudsman decided to raise the issue of solitary confinement and lack of human contact in Norwegian prisons in a separate Special Report to the Storting (see separate article in Chapter three).

The Directorate of Correctional Service's management stated in 2019 that measures to prevent solitary confinement would be one of its most important focus areas in the time ahead.

Use of means of restraint

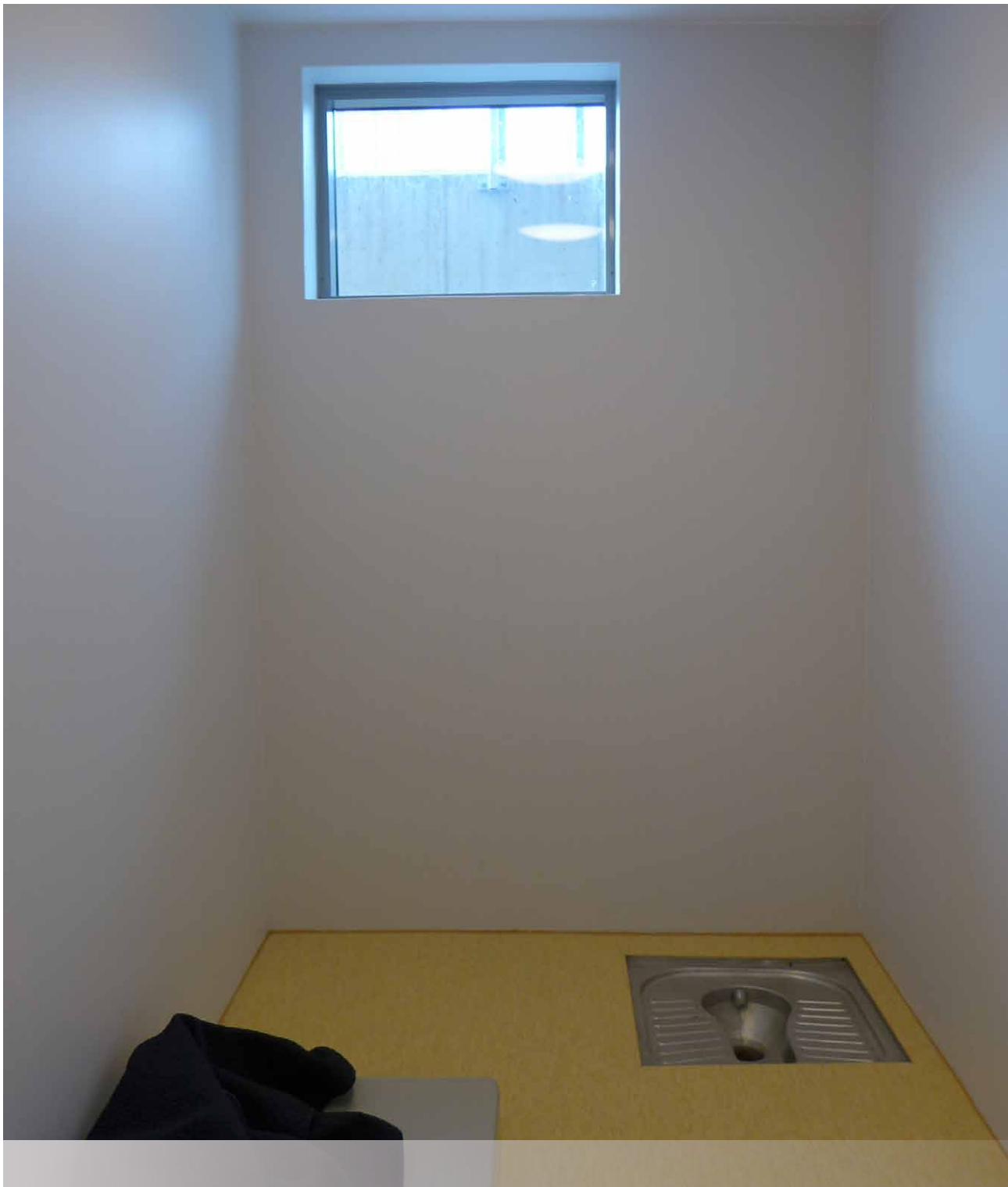
The use of means of restraint, such as security cells and restraint beds, is among the most intrusive measures that can be implemented in prison. Security cells are a highly intrusive form of solitary confinement in a bare cell, and a restraint bed entails strapping an inmate to a bed. The measures are so serious that we always go through the prison's practice for this in particular detail during our visits, both when inspecting the cells where such measures are carried out and when reviewing documentation such as administrative decisions and supervision logs.

During several of our prison visits, we have identified conditions that constitute a risk to the inmates' health and legal guarantees regarding means of restraint, and, in particular, security cells.

We have repeatedly criticised a lack of documentation demonstrating that an administrative decision was strictly necessary, or whether there were grounds for upholding the measure. We have also criticised several prisons for conducting routine body searches before placing inmates in security cells, and pointed out that inmates have inadequate clothing during the stay and that there is a need for daily supervision by medical personnel.

In March 2019, the Directorate of Correctional Service adopted revised guidelines for the Execution of Sentences Act's provisions on the use of means of restraint.[34] In the guidelines, the directorate included important clarifications to strengthen legal safeguards in relation to the use of restraint measures. These are in line with our recommendations to the prisons in a number of areas. Among other things, it was clarified that when security cells or restraint beds were used, the administrative decision should always state which less intrusive measures had been tried or were considered insufficient. The guidelines set out requirements for the information to be included in supervisory logs and new guidelines on body searches, supervision and clothing for inmates in these situations.

34 The Directorate of Correctional Service, Guidelines to the Execution of Sentences Act Section 38, revised 15 March 2019.



The use of security cells is a highly intrusive form of solitary confinement. This photo was taken during one of the NPM's prison visits.

Visits in 2019

In 2019, the Parliamentary Ombudsman's National Preventive Mechanism carried out several visits to child welfare institutions and mental healthcare institutions. All but one visit was carried out in the autumn 2019. We have also followed up six visits that were carried out during 2018.

The Child Welfare Service

Buskerud and Vestfold Emergency Youth Centre, Barkåker

20–21 May 2019

Barkåker is a state-owned emergency institution. The institution has eight places and receives adolescents from the age of 13 to 18 years. The Parliamentary Ombudsman's National Preventive Mechanism (NPM) visited Barkåker on 20–21 May 2019.

The adolescents felt that they were well received when they arrived at the institution, and the institution worked hard to make the adolescents feel included both individually and as a group. The adolescents explained that they were respected, treated well, and that they could speak out if they disagreed with something.

Barkåker had made many administrative decisions on the use of force in situations of acute danger both in the present and in previous years. A high number of these decisions concerned a small number of adolescents.

Several days could pass, sometimes weeks, from the coercive measure was implemented until the staff reviewed the administrative decision on the use of coercion measure with the adolescent concerned. Many of the administrative decisions were not reviewed with the adolescents, most often because the adolescents did not want to. It was therefore difficult to gain a good understanding of their view and experience of the use of coercion.

The unit did not have procedures for documenting that continuous assessments were made of whether to uphold or set aside an administrative decision on restricted freedom of movement. Some decisions on restricted freedom of movement concerned restrictions both in and outside the institution. This was usually about an adolescent staying in a separate apartment in the unit, separated from the other residents. There is a risk of adolescents in practice being isolated over a prolonged period from their peers and others who are not staff at the institution.

Staff and management were aware of how intrusive body searches are, and the threshold for conducting a body search appeared to be high. The NPM nonetheless found an example of a body search that did not safeguard the person's need for safety and dignity and did not follow a trauma-sensitive approach.

The exterior doors of the institution were locked, and residents who wished to leave or enter the institution had to contact a member of staff to unlock the doors. Locked doors during the day are legally problematic, especially when it concerns adolescents who are not placed at the institution against their will. Findings indicated that residents who so requested were indeed let out, however, it seemed that the locked doors added tension to situations of conflict occurring between residents and staff.

Barkåker had a separate 'isolation room' in the institution's administration building. The room resembled a police custody cell and came across as frightening and unfit for safeguarding children and adolescents' safety, integrity and dignity. It was only to be used in situations of acute danger but had in the past 18 months also been used for other purposes.

During the visit, we found that several adolescents with serious mental health problems had been placed at Barkåker in the last few years. Several of these adolescents had stayed at Barkåker for a longer period than what is recommended for emergency institutions. Several of them harmed both themselves and others, which resulted in coercion being used extensively in relation to some of these adolescents.

The management at Barkåker confirmed that they felt they were under pressure from the police and other parties concerning the institution's use of coercion. We found an example from the past year of an adolescent whose electronic means of communication and freedom of movement were restricted, and the justification given in the administrative decision was primarily that the police wanted to protect others outside the institution. This is not in line with the Rights Regulation.

The Ombudsman has requested an update on how Barkåker is following up the recommendations by 15 January 2020.

Buskerud and Vestfold Emergency Youth Centre, Barkåker

Humana Child Welfare Service East, Jessheim and Hol gård

4–6 September 2019

The NPM visited Humana East, Jessheim section and Hol gård section in September 2019. Visits were made to both places at the same time. Both Jessheim section and Hol gård section are long-term units for adolescents aged 13 to 18, placed there due to serious behavioural problems.

There had been a high staff turnover in both units in 2018 and 2019, both at employee and management level. Instability and the high staff turnover rate could pose a risk of insecurity and lack of continuity for the adolescents. It could also mean that some of the staff did not have the training and expertise required. We found that more training was needed to ensure that everyone working in the units has the knowledge and skills needed to safeguard the target group that the institution is approved for.

Many changes and a lack of management presence pose a risk of inadequate continuity in, and overview of, the running of the units and the work with the adolescents.

During the visit, we noticed, that important routines and procedures had not been sufficiently implemented. We also found that there was lack of records and an inadequate overview of the use of coercion and intrusive measures, such as returning an adolescent to the institution against his or her will after an attempted escape. The administrative decisions and records contained several instances of inadequate descriptions of the sequence of events before the use of coercion, which measures had been attempted or why it was necessary to make a decision on the use of coercion. We also found that incorrect information had been provided in decisions on the use of physical force.

Humana Child Welfare Service East

In addition, we discovered that illegal use of coercion had been used repeatedly in situations of acute danger. Management did not appear to have a complete overview of these situations and we did not find that adequate measures had been implemented to prevent future situations where adolescents could be subjected to illegal use of coercion. This is not in accordance with the duty to prevent the use of coercion.

The report also looks at how weak language skills could affect legal safeguards. An overall assessment of language as a vulnerability and risk for the adolescents, assessments on how to handle this risk, as well as documentation of the need for an interpreter were lacking. The overview and documentation of situations where the institutions had asked for police assistance were also inadequate.

Humana has been asked to provide information about how it is following up the recommendations made by the Ombudsman by 30 January 2020.

Jong Youth Centre

25–26 September 2019

The NPM conducted an unannounced visit to Jong Youth Centre on 25–26 September 2019. Jong Youth Centre is a state-owned child welfare institution with the capacity to house up to five adolescents aged between 13 and 18 with serious substance abuse problems. The average time spent at the institution is eight months.

In summary, Jong Youth Centre came across as a pleasant place, decorated with consideration for the residents who were to stay there. However, the kitchen and basement, which included an activity room for the adolescents, were locked and only available to the adolescents upon request and there was sufficient staff available.

Jong Youth Centre has, since 2010, been one of two child welfare institutions that have implemented a method based on contingency management[1] for treatment of alcohol and drug abuse. The method is a new form of treatment for adolescents with an alcohol or drug problem in child welfare institutions. The method is knowledge-based, but it has not been previously tested in child welfare institutions or in institutions where people are placed against their will. The method's handbook outlines research that gives grounds for scepticism in relation to using the method in the context of an institution. However, there appeared to be little knowledge or recognition of the limitations of the method among staff and management.

Jong Youth Centre

1 «Læringsbasert rusbehandling» in Norwegian.

Nymogården, Stendi Region North

The institution's clear methodical profile appeared to ensure that staff underwent solid, systematic training, and that a uniform practice was in place. Management considered the institution a treatment centre and emphasised that it was not a home. This is something the Ombudsman criticises in the report, as every child welfare institution should be a home for the children who are placed there.

The method that governed the running of the institution was characterised by stringent rules and procedures, with extensive house rules and procedures. This led to many restrictions in the day-to-day life of the adolescents, and extensive use of less intrusive coercion. The adolescents' right to freedom of movement, electronic communication and the right to privacy were restricted in ways that are not in accordance with the child welfare legislation. Findings during the visit indicated that illegal use of physical force had taken place.

We identified shortcomings in documenting the grounds for use of coercion and force, and also in the procedures for reviewing situations where coercive measures had been used and measures to prevent the use of coercion. This applied both to use of force and coercion based on an administrative decision and the use of force without a decision.

The Parliamentary Ombudsman's impression is that there was good cooperation between Jong Youth Centre, the child welfare service and the child and adolescent psychiatry units. The adolescents' health appeared to be taken care of in a responsible manner.

The report from the visit will be finalised in the course of 2020.

Stendi Region North

12–14 November 2019

The NPM visited the institution Nymogården on 12–14 November 2019. The institution is owned by Stendi and is located in Stendi Region North. The Nymogården institution is made up of six separate houses, of which three form a cluster, and three other houses are spread across different locations. The units are either approved as care placements or placements due to serious behavioural problems and receive adolescents from the age of eight to eighteen years.

The report from the visit will be finalised in 2020.

Mental healthcare

Stavanger University Hospital: Child and Adolescent Psychiatry Units

8–10 October 2019

The NPM visited the Child and Adolescent Psychiatry Units at Stavanger University Hospital on 8–10 October. This is an inpatient's clinic in the mental health care service for children and adolescents with three wards. One of the wards is intended for children up to 13 years, and the remaining two are for adolescents aged between 13 and 18. The Ombudsman visited all three wards.

The report from the visit will be finalised in 2020.

Stavanger University Hospital:
Child and Adolescent Psychiatry Units

Recommendations from visits in 2018

After each visit, the Parliamentary Ombudsman publishes a report describing its findings with recommendations for how the institution can better prevent the occurrence of torture, inhuman or degrading treatment. We ask all the places we visit to provide written feedback on how the recommendations have been followed up after the visit. The NPM has followed up the recommendations made after five visits carried out in 2018. The summary of the other visits can be found in the 2018 annual report. Exceptionally, the visit to Oslo prison took place late in 2018 and is therefore summarised in this report

The County Psychiatric Department, Vestfold Hospital Trust

10–12 April 2018

The Parliamentary Ombudsman's visit showed that the emergency psychiatric units, particularly a number of the segregation units, showed signs of wear and tear and were not suitable for safeguarding patients' safety and dignity. The activity programme seemed poor, and there was very little opportunity for outdoor activities. In the follow-up letter, the hospital stated that the move to another building in 2019 would improve the physical conditions, and create more opportunities for outdoor activities for all patients. In the meantime, the hospital would ensure dignified conditions and that the patient rooms were satisfactorily cleaned and maintained.

The County Psychiatric Department, Vestfold Hospital Trust

The implementation of an interdisciplinary treatment plan would also ensure a better activity programme for the individual patient.

The hospital has developed a separate action plan with follow-up points for each recommendation made by the Parliamentary Ombudsman. The action plan is to be followed up with status reports as a regular item at the unit's management meetings.

Following the visit, the hospital – on the recommendation of the Parliamentary Ombudsman – has extended its use of information material. Patients now receive information about their rights in a brochure upon arrival and information is posted on a notice board in the unit. The information given to the patients is to be followed up through a user survey, and the information flow will also be a topic during the discharge conversations with the patients.

The use of restraint measures was extensive at Vestfold Hospital compared to national figures. The figures showed an increase in the use of mechanical restraints and short-term physical restraint at the emergency sections last year, despite measures to reduce the use of restraint measures. Several factors were identified in connection with the visit that indicated a real risk of excessive use of coercion.

As a result of the recommendations made following the Parliamentary Ombudsman's visit, the hospital developed guidelines on the use of coercion and improved teaching and training in how the units can prevent the use of coercion. Training in record-keeping and registering decisions in connection with the use of coercion was also carried out.

Spit hoods were removed from the unit immediately after the visit, and the hospital went through its procedures for cooperation with police.

All of the emergency units at the hospital had separate night shift staff. It seemed that the high focus on security and a somewhat strict framework affected the night shift staff.

We also found that the night shift staff rarely participated in general staff training. Although the hospital found it expedient to continue the separate night shift staff arrangement, it was decided that all night staff must participate in selected teaching and one-day meetings. A new rule has also been introduced whereby night shift staff are required to complete one evening shift before they start working night shifts.

We found some examples of good practice for segregation, where human contact and joint activities with the staff throughout the day were emphasised. Even so, we noted that the number of segregation decisions had increased and some of these were for long periods. The hospital had updated its procedure for segregation in order to ensure that segregation did not lead to isolation.

Bergen Hospital Health Trust, Sandviken Psychiatric Clinic

14–16 August 2018

The NPM's visit to Sandviken psychiatric clinic under the auspices of Bergen Hospital Health Trust identified several troubling issues, including in relation to the use of segregation and isolation. In May 2019, the clinic submitted its follow-up response to the report, and sent supplementary information at the Ombudsman's request in December 2019.

All the sections visited at Sandviken had a segregation unit where patients can be kept separated from the other patients. A key finding was that segregation was conducted in premises with undignified conditions. The follow-up plan devised after the Parliamentary Ombudsman's visit stated that the segregation units should be designed to have normal, positive sensory impressions. This entails decoration on the walls, the use of ceiling lights, furniture and the possibility for patients to look out the windows.

Bergen Hospital Health Trust, Sandviken Psychiatric Clinic

The clinic has also stated that the segregation units shall be designed so that the patients can take part in meaningful social interaction, and that the clinic will alter the segregation units and establish segregated living rooms in the units. The clinic has also decided to discontinue the use of rooms set up with restraint beds that were located in the segregation units during the Parliamentary Ombudsman's visit.

According to the letter sent by the clinic in December, changes have begun on the layout and a collaboration has been initiated with an interior architect.

The opportunity to spend time outdoors will become a regular item in the milieu therapy plan for all patients. A decision had been made to improve the available outdoor areas, and they also plan to improve the indoor areas and set up a music therapy room.
In the report, the Parliamentary Ombudsman expressed concern over the extensive practice of using transport restraints as a mechanical restraint and pointed out that it constituted a risk of lowering the threshold for using coercive measures. We found that spit hoods had been used in exceptional cases to cover the patients' faces while they were being restrained. As a result of the Parliamentary Ombudsman's visit, new procedures were implemented to avoid prolonged use of restraint belts, and the spit hoods were removed from all the clinic's units.

A review of the decisions on forced medication revealed several weaknesses in terms of how the decisions were written. The clinic has subsequently changed its procedures by ensuring that the person responsible for making the decisions always evaluates whether forced medication is strictly necessary and proportionate. Following the Parliamentary Ombudsman's recommendations, the clinic has also changed its internal procedures for the use of electroconvulsive therapy (ECT) on the grounds of necessity and introduced a checklist for every ECT treatment on the grounds of necessity. In the report, the Ombudsman pointed out that the patients' right to information and participation was not satisfactory. As part of the follow-up, the clinic has designed a common standard for information material for the clinic's patients. This included information about how the right of appeal can be safeguarded.

Skjerfheimkollektivet

Skjerfheimkollektivet

18–20 September 2018

Skjerfheimkollektivet is a residential and treatment institution for adolescents between the ages of 15 and 18 with serious substance abuse problems. The institution is a department under "Buskerud, Vestfold and Telemark behandling ungdom", owned by the Norwegian Children, Youth and Family Affairs Service (Bufetat).

Several recommendations were made after the Parliamentary Ombudsman's visit in 2018. Skjerfheimkollektivet provided a systematic and detailed description of how it was working on following up the recommendations, both at management level and throughout the staff.

In the years before our visit, Skjerfheimkollektivet had made a number of changes to the way in which they worked with the residents. The changes meant using a more individual approach to the residents' treatment and in their everyday lives, less rigidity in operations and more focus on the residents going to school or working outside the institution. The Parliamentary Ombudsman recommended that the institution's written procedures were changed so that they fully reflected the integrity and rights of the adolescents. Skjerfheimkollektivet followed up the report by revising their institutional plan and their procedures, so that these were in accordance with the actual practice at the institution.

Several new courses and changes in staff training were also implemented as a result of the recommendations made following the visit.

The use of coercion may not be routinely exercised as a normal part of the institution's treatment regime or other operations. Skjerfheimkollektivet stopped using Section 22 of the Rights Regulations to justify admission camps and treatment-related 'motivational trips', and they changed the practice so that trips only take place on a voluntary basis. Skjerfheim also implemented a number of measures to work more systematically on preventing the use of all types of coercion. Among other things, it was emphasised that 'the use of coercion, as far as possible, should be discussed with the adolescents before implementation'.

Skjerfheimkollektivet expressed that they found it challenging to implement restrictions on the adolescents' freedom of movement only at the institution. The Parliamentary Ombudsman emphasised that it is the institution's responsibility to ensure that the adolescents' freedom of movement is not restricted in a way that in practice isolates them from the other residents.

The report pointed out that the administrative decisions on the use of coercion and record keeping had a number of weaknesses as regards to justification, completion and dating. Several recommendations were made on how Skjerfheimkollektivet could ensure that procedures on the use of coercive measures were in accordance with the applicable legislation. The recommendations were followed up through several measures.

Recommendations were also made to improve the rooms used to perform coercive measures (urine samples and body searches). As a result of this, Skjerfheimkoollektivet has agreed with the Directorate of Public Construction and Property Management (Statsbygg) that these rooms are to be improved and renovated over the course of 2019.

Østfold Hospital, Kalnes

Østfold Hospital, Secure Psychiatric Section and Geriatric Psychiatric Section

9–11 October 2018

The NPM made two visits to Østfold Hospital on 9–11 October 2018 – one to the geriatric psychiatric section and one to the secure psychiatric section. The sections are part of the department of psychiatry and adult habilitation at Østfold Hospital.

Weaknesses in the documentation of the use of restraint measures were identified during both visits. There was a general low incidence of use of coercion in the geriatric psychiatric section, although the Ombudsman also found that not all situations that involved restraining a patient against his or her will were registered as administrative decisions. There was uncertainty among the staff as to whether they could physically restrain a patient for a period before a decision had been made and, in such case, how long this period could last. As a result, the section did not have confirmed figures for the use of coercion and the patients' right to appeal was not sufficiently safeguarded.

In the security sections, mechanical restraints were used more often than what was found in other, similar institutions.

In both sections, there were several instances of very prolonged use of restraints, and mobile restraints were also used extensively.

The two security sections, which both have the same function and the same number of places, had very different practices when it came to use of coercion. The staff at all levels had little knowledge of these systematic differences between the sections. There was also little understanding of what and if the sections could take active measures to reduce the use of coercion.

As a result of the NPM's recommendations, Østfold Hospital set up a working committee to devise improvement measures. The working committee, whose deadline for finalising the work was 1 November 2019, was tasked with several areas to improve, such as mapping the applicable procedures for the use of coercive measures in all departments, reviewing house rules and developing new procedures and training measures. Based on this, the hospital has been given a deadline of January 2020 to submit a written response to the Ombudsman with the results of this major quality improvement work.

Bergen Prison

Some of the recommendations were addressed immediately, such as the hospital developing technical solutions to collect data on decisions on the use of coercive measures in the different sections. A system has also been developed to document whether a patient has received a debrief conversation after being subjected to coercion.

The hospital has also made certain changes to the physical conditions in the section, such as painting the segregation units to reduce their sterile feel. The restraint straps, which hung visibly from the patient beds in the segregation units, have also been removed.

The house rules in all the sections have been revised, and wording that were in violation of the legislation were immediately removed after the visits. During the visit at the security section, it emerged that the house rules in one of the sections restricted the use of mobile phones in excess of that provided for in the Mental Health Care Act.

Bergen Prison

2–4 May 2018

The visit to Bergen Prison was part of the follow-up of the Parliamentary Ombudsman's report after its previous visit in 2014. The main purpose of the visit in 2018 was to investigate the prison's practices in connection with exclusion from common areas and time spent outside the cells.

Bergen Prison is Norway's second largest prison and has an ordinary capacity of 265 places, divided between 209 high security places and 56 lower security places. The NPM's visit did not include the prison's lower security section.

The recommendations made after the visit appeared to have been thoroughly followed up. Changes, such as rehabilitation of the security cells, including new dimmable lights, a calling system, digital clock and new paint colours, had been implemented.

After the visit, the Parliamentary Ombudsman made several recommendations regarding the use of security cells and restraint beds. The Ombudsman recommended that the prison immediately ensured that administrative decisions regarding the use of security cells were made in accordance with the requirements set out in current laws and guidelines. The prison reviewed the decisions that were inadequate after the visit. They were discussed at management meetings and used in the training of staff. The staff also underwent training and supervision in relation to supervision procedures and record-keeping.

Bergen Prison changed its procedures to ensure they are in accordance with the recommendation that inmates mainly should be able to use their own clothes in the security cells. The prison's internal guidelines for the use of restraint beds were also changed. During the visit, weaknesses were identified in the procedures and practices relating to using restraint beds and security cells

in relation to minors. Measures have also been implemented to ensure satisfactory treatment of minors in the future.

The prison health services had also implemented measures after the visit. The health services had become familiar with the content of the Istanbul Protocol, which includes important principles for identifying, documenting and reporting any abuse that takes place before or during the transfer to prison. The health services had obtained a camera in order to document and register possible injuries and had also introduced procedures for documenting injuries to inmates. The prison health service was working towards reaching an agreement with one of the municipality's female GPs, so that female inmates could be referred to her. They had also held a course on medication for all the prison officers.

Oslo Prison

19–22 November 2018

The NPM visited Oslo Prison on 19–22 November 2018. The visit took place too late in the year to be included in the annual report for 2018, which is why both a summary and a review of the follow-up is provided here.

The prison is one of Norway's biggest, with 240 places for male inmates. The NPM's visit was limited to Section B (Bayern).

Oslo Prison is primarily a remand prison and is the prison in Norway with the highest number and highest percentage of inmates on remand. This impacts the operations in a number of ways.

Summary of the visit

Oslo Prison was in need of extensive maintenance, and the building's design was not expedient. The building had few natural communal areas. The NPM was informed that renovation had begun in some of the cells and bathrooms where the conditions were worst. The exercise opportunities for inmates excluded from the company of other inmates warranted criticism. The prison had what were referred to as exercise cells on the roof of the building. The cells had walls and ceilings that prevented views of the outside or the sky. The prison's exercise areas were sparsely equipped and it was not possible to sit under cover. The Parliamentary Ombudsman's visit showed that the healthcare department's procedures for medical assessments were not in line with international standards, which stipulate that medical assessments must take place within 24 hours. The written information given to inmates in the admission phase at Oslo Prison was also inadequate.

The visit showed that the inmates endured widespread lock-ups and solitary confinement. A clear majority of inmates in Oslo Prison were locked in their cells for more than 16 hours a day. A significant proportion of inmates were locked in their cells for more than 22 hours per day, a situation equivalent to solitary confinement according to international standards. The weekends were characterised by the inmates being locked up for even longer periods. No administrative decision had been made for most of the inmates who were locked up for 22 hours per day. The Parliamentary Ombudsman pointed out that the extensive use of lock-ups was in breach of international human rights standards and constituted a clear risk of inhuman treatment. It also means that a high proportion of those subject to solitary confinement in Oslo Prison are not visible in the solitary confinement statistics.

During the NPM's visit, we found few measures to compensate for the detrimental effects of solitary confinement for inmates who were excluded from the company of other inmates.

The prison officer's contact with the inmates was often limited to the context of exercise. For this reason, inmates excluded from the company of others were not routinely seen to by medical personnel. The Parliamentary Ombudsman expressed concern regarding this lack of follow-up.

The visit also identified inadequate documentation relating to the use of security cells. The documentation gave rise to concern about the prison's supervision procedures and opportunity to safeguard persons who are placed in a security cell. The documentation did not provide a basis to assess whether inmates in security cells at the prison received proper and satisfactory medical supervision. Although the prison had its own healthcare department and a psychiatric outpatient clinic, the de facto availability of health services was limited and subject to long waiting times. The prison health services was organised in a way that did not sufficiently address confidentiality between inmates and the health services. This included the prison officers performing assessments of medical needs and acting as gatekeepers for the health services. The prison health services did not engage in outreach activities or preventive work. The medical personnel had limited contact with the inmates and were not responsible for the distribution of medication. Overall, the Parliamentary Ombudsman concluded that there was a significant risk that inmates in vulnerable situations, who did not seek medical assistance on their own initiative, would not be identified before their medical situation became acute.

It also came to light that the healthcare department found that remand inmates regularly missed their appointments with the specialist health services outside the prison because the police did not come to escort them. The healthcare department did not have a system for registering the cancelled appointments as nonconformities. This represents a clear risk of violation of patients' right to satisfactory treatment. In all, the health services at Oslo Prison appeared to be of an inadequate scope to be able to safeguard the health of inmates in a satisfactory manner.

Follow-up of the visit

Oslo Prison and the healthcare department submitted detailed feedback to the Parliamentary Ombudsman after the visit. The submitted feedback showed that some immediate action had been implemented, in addition to more extensive quality-improvement work that will take somewhat longer to implement.

Both the prison and the healthcare department emphasised in their feedback that they could not meet certain recommendations, in particular those related to solitary confinement, due to the current staffing, building and resource situation.

After the visit, the prison purchased benches with roofs for both exercise yards, and a new, bigger greenhouse for the exercise yard in connection with the section for inmates with extra need for supervision. The prison recognises the need for major improvements, but states that it is uncertain whether the prison is to continue in its current building or whether a new one is to be built. Major improvements will not take place until this has been clarified.

After the visit, both the healthcare department and the prison improved the admission procedures. A working committee has been appointed to prepare new information material, and the procedures now make it clear that new inmates are to speak to medical personnel within 48 hours.

The reply letter from the prison acknowledges that the extensive use of lock-up is undesirable. At the same time, it is underlined that the recommendation of ensuring that inmates spend eight hours outside their cell cannot be realised, due to the current resource situation. After the visit, the prison does however make reference to strengthening measures to compensate for the detrimental effects of solitary confinement and to establishing new measures.

Oslo Prison

New procedures ensuring inmates excluded from the company of others are supervised once an hour have also been implemented.

A new registration system for all activity has been introduced after the visit in order to obtain a better overview of the situation. In dialogue with the prison administration, the Parliamentary Ombudsman has emphasised that it is not only the scope, but also the quality of human contact, that is vital to ensuring the Mandela rules are not violated.

After the visit, the prison administration explained the changes in procedures for keeping administrative decisions and records that to a greater extent ensure the inmates' legal safeguards and enable internal and external control of the use of restraint measures at the prison.

The healthcare department changed several of its procedures to ensure better access to healthcare services for inmates, such as creating new procedures that ensure daily updates given about the inmates' healthcare requests; notification of inmates excluded from company; and registration of cancelled escorted visits as non-conformities.

Furthermore, new procedures have also been introduced that to a greater extent ensure confidentiality between the inmates and the healthcare service. The healthcare department stated that requests for healthcare assistance are now submitted in envelopes, which are only read by the healthcare department.

After the visit, the healthcare department personnel also familiarised themselves with the guidelines in the Istanbul Protocol. The department stated that it has, as a continuation of this, increased the focus on mapping physical injuries and psychological damage that have been sustained in prison or in contact with the police.

Due to the current resource situation, the healthcare department stated that it cannot increase its efforts to work in a preventive manner and attend to inmates in vulnerable situations who do not seek medical help. However, the department will test a procedure where inmates, who do not contact the healthcare department within a given time frame, will be called in for a follow-up conversation.

National Dialogue

The national dialogue in 2019 primarily concerned the follow-up of the Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons. This also led the National Preventative Mechanism (NPM) to participate in Arendalsuka[1] for the first time, hosting an event dedicated to the Special Report.

The advisory committee

The NPM's advisory committee consists of seventeen members from organisations that have expertise in areas that are important to our mandate. The advisory committee members provide knowledge, advice and input on the preventive work.

In consultation with the advisory committee, the number of meetings in 2019 was reduced from four to three, but the length of the meetings was extended. This provided the opportunity to take a deeper look into particular topics and made it easier for members who have to travel far to participate. During the meetings, the NPM informed the members about their work, and received input from the committee members. In addition, the NPM kept in dialogue with the members of the committee when necessary.

The topics of the advisory committee meetings in 2019 have been the NPM's thematic report on segregation in mental healthcare institutions, the Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons and the NPM's visits. In addition, other parties were invited to inform the members about relevant topics. During one of the meetings, the Board of Health Supervision informed members about its nationwide supervision of child welfare institutions in 2018, and in another, Professor Nora Sveaas talked about her work as a member of the UN Subcommittee on Prevention of Torture (SPT).

Current members

In 2019, three new members joined the NPM's advisory committee. The committee comprised representatives from the following organisations in 2019:

- Amnesty International Norway
- Juss-Buss (Free legal aid service run by law students)
- The Equality and Anti-Discrimination Ombudsman
- The National Human Rights Institution
- The Norwegian Alliance for Carers
- The Norwegian Association for Persons with Development Disabilities (NFU)
- The Norwegian Association of Youth Mental Health
- The Norwegian Bar Association´s Human Rights Committee
- The Norwegian Helsinki Committee (NHC)
- The Norwegian Medical Association, represented by the Norwegian Psychiatric Association
- The Norwegian Organisation for Asylum Seekers (NOAS)
- The Norwegian Organization for Children in Care (NOOC)
- The Norwegian Psychological Association's Human Rights Committee
- The Norwegian Research Network on Coercion in Mental Health Care (Tvangsforsk)

- The Ombudsman for Children
- Wayback – Foundation for the Rehabilitation of prisoners
- We Shall Overcome

Other formal cooperation

The Parliamentary Ombudsman is also represented on the advisory committee of the Norwegian National Human Rights Institution (NIM), which regularly discusses topics of general interest to the Ombudsman and of special interest to the prevention efforts. The NPM maintains ongoing contact with the Ombudsman for Children and the Equality and Anti-Discrimination Ombudsman.

Senior Advisor Mette Jansen Wannerstedt gives a talk to the Norwegian Bar Association.

New members on the advisory committee: Thomas Johansen from the Norwegian alliance of children with experience from institutionalized child welfare, Anne-Grethe Terjesen from the Norwegian Alliance for Care and Johan Lothe from Wayback –Foundation for the Rehabilitation of Prisoners.

Information work, knowledge dissemination and education

The Special Report on Solitary Confinement and Lack of Human Contact in Norwegian Prisons was submitted to the Storting in June. In August, the report was published for a wide audience in connection with a debate during Arendalsuka. The debate focused on what the use of solitary confinement in prison means for the individual and for society, and how best to address the challenges posed by the practice of solitary confinement in Norwegian prisons. Close to one hundred people attended the panel discussion on the report's content and findings. The debate was also streamed live.

Participating in the debate were:

- Maria Aasen-Svensrud, Member of the Storting, the Standing Committee on Justice, the Norwegian Labour Party
- Kristoffer Sivertsen, State Secretary, the Ministry of Justice and Public Security, the Progress Party
- Nils Leyell-Finstad, Prison Governor, Oslo Prison
- Helga Fastrup Ervik, Head of the NPM, the Parliamentary Ombudsman

Arendalsuka also provided the NPM with the opportunity to participate in other events, directly relevant to the sectors the NPM works with. In addition to our own debate, the NPM's staff attended 56 different events during Arendalsuka. This provided the NPM staff with good opportunities for dialogue and input.

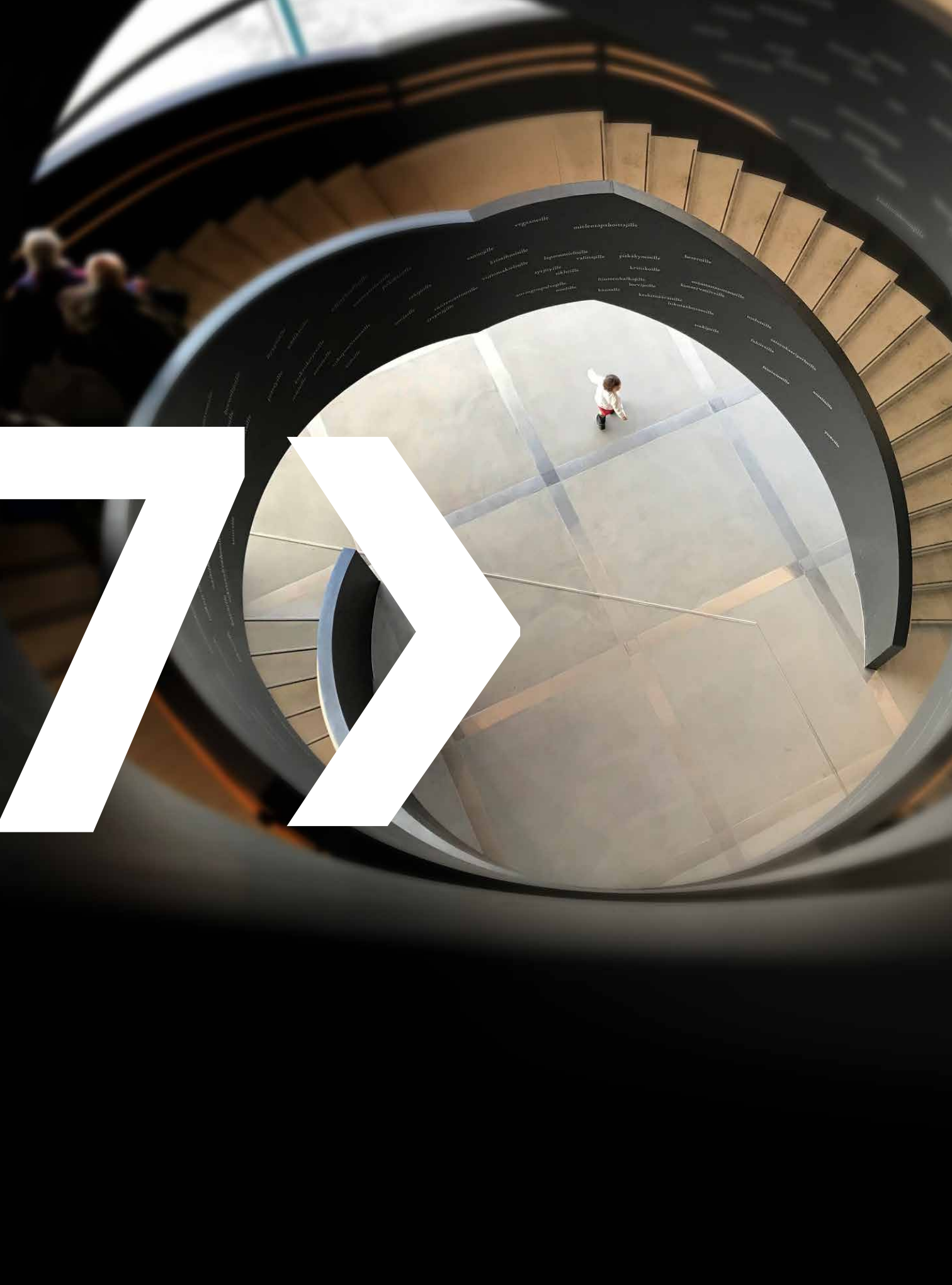
The Ombudsman and the NPM staff gave a number of presentations at conferences and seminars during the year, including (for an exhaustive list, see *Activities in 2019*):

- The Norwegian Association for Penal Reform's penological conference on legal safeguards in prisons
- The Norwegian Bar Association's Human Rights Seminar – talk on the use of coercion against children in institutions
- Lecture to Red Cross volunteers visiting the police immigration detention centre at Trandum
- The criminal law conference 2019: Lecture on challenges in the Correctional Services
- Leadership conference for the Office for Children, Youth and Family Affairs – Region South, on the Parliamentary Ombudsman's work
- Conference on solitary confinement, hosted by the Correctional Service of Norway Staff Academy (KRUS), on the Special Report to the Storting on Solitary Confinement in Norwegian Prisons
- The Supervisory Commission Conference 2019, presenting the most recent findings of the NPM from the mental healthcare sector
- Lucy Smith's Children's Rights Day – talk on how the work of the NPM can promote change

Dialogue with the authorities

Follow-up of the visits we have conducted is an important part of our dialogue with the authorities. Much of our dialogue with the Norwegian authorities in 2019 has been related to the work on the *Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons*, following its submission to the Standing Committee on Scrutiny and Constitutional Affairs. During the year, we have met with the Ministry of Health and Care Services, the Ministry of Justice and Public Security, the Directorate of Health and the Directorate of the Correctional Service to present the Special Report. The Special Report has also been presented to other relevant parties, for instance the Storting's Standing Committee on Justice, and trade unions, including the Trade Union for Correctional Officers (KY), the Norwegian Medical Association and the Norwegian Nurses' Association. Several specialist committees and all the political factions in the Storting have also been offered a presentation of the Special Report.

Head of the NPM, Helga Fastrup Ervik, during a panel discussion in connection with launch of the report 'Women's experiences as inmates in Norwegian prisons'.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International Cooperation

The National Preventive Mechanism (NPM) is in contact with multiple international parties, sharing experiences with and placing itself at the disposal of international human rights organisations and others that visit Norway.

Nordic Prevention Network

The Nordic Prevention Network held two meetings during the year. The network comprises representatives from all the national preventive mechanisms in the Nordic countries with equivalent mandates to the Parliamentary Ombudsman under the Optional Protocol to the UN Convention against Torture (OPCAT). The Nordic networking meetings are important forums for exchanging knowledge, experience and practice among the Nordic countries and providing new impetus to their work.

The first meeting of the year took place in Helsinki in January 2019. The topic of the meeting was the methodology employed during preventive visits, risk factors during the transportation of people deprived of their liberty and of persons with disabilities. This spurred a number of ideas for focus areas and methodology for visits to this sector. Examples such as attending to hygiene needs, self-determination in everyday life and care during the last phases of life were highlighted as important focus areas for elderly persons in nursing homes.

The second network meeting was held in Reykjavik in September 2019. The topic of the meeting was dilemmas that arise when treatment involves coercion. The network also visited Kleppur, a closed psychiatric hospital for patients who have been committed. A tour of the hospital was organised, and various restraint measures were presented and discussed.

The Special Rapporteur on the Rights of Persons with Disabilities

The Parliamentary Ombudsman welcomed the UN's Special Rapporteur on the Rights of Persons with Disabilities, Catalina Devandas Aguilar, when she was in Norway to investigate how Norway honours the UN Convention on the Rights of Persons with Disabilities (CRPD).

The Special Rapporteur pointed out that Norway must increase its efforts to reduce the use of coercion in mental healthcare institutions. She also brought attention to the healthcare services available to children and young persons, and expressed concern that the institutional detention of children and young persons should be replaced by good mental healthcare services. The Special Rapporteur paid special attention to the content of the *Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons*, and was concerned about the healthcare services for people with mental disorders or mental disabilities in Norwegian prisons. She also encouraged the NPM to visit institutions for elderly and people with mental disabilities. The Special Rapporteur emphasised that Norwegian legislation had to comply with the commitments outlined in the CRPD, and she was concerned about the use of electroconvulsive therapy (ECT) on grounds of necessity.

International visits to the National Preventive Mechanism

We have received a number of international delegations during the year that sought to learn how preventive work is organised in Norway and about the NPM's work methods. We have also taken part in events abroad.

In January, the NPM attended a seminar organised by the Danish organisation DIGNITY, where a report was presented on good practice among NPMs.

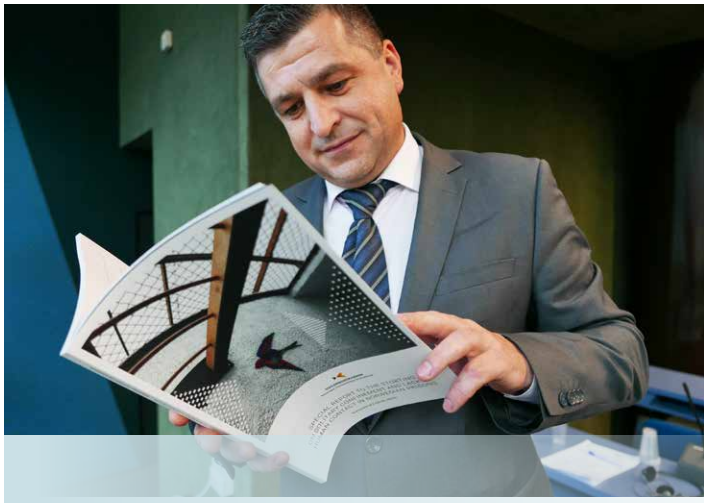
In December, the NPM received a visit from its Moldovan colleagues who were in Norway for a study tour. We exchanged experiences from working on the prevention of torture, inhuman and degrading treatment in our respective countries. The NPM has also received visits from several delegations from the United States. We received a visit from a delegation from the State of Louisiana, which works on improving the prison conditions in the State. The delegation comprises representatives from universities, NGOs and local authorities, and they were particularly interested in prison oversight bodies.

Representatives of the Nordic national preventive mechanisms during a meeting in Helsinki in January 2019.

The NPM gives a talk to representatives of the Vera Institute of Justice from New York. The delegation visited Norway to learn about solitary confinement in Norwegian prisons.

During the meeting, the delegation gained insight into the NPM's methods and execution of visits, findings and recommendations from Norwegian prisons, and how the Parliamentary Ombudsman follows up the recommendations through its work with the authorities and the Correctional Service. The same applied to a delegation of participants from Washington State and Louisiana, organised by the Vera Institute of Justice in New York, which works to reduce the use of solitary confinement in the US prison sector. We also received a visit from Professor Steve Chanenson of the Villanova University in Pennsylvania. He is part of a research team that works with the Directorate of the Norwegian Correctional Service and Pennsylvania Department of Corrections.

In October, the NPM attended the 30th anniversary of the European Committee for the Prevention of Torture (CPT). The anniversary was hosted by the Association for the prevention of torture (Association pour la prévention de la torture (APT)), the Council of Europe and the OSCE Office for Democratic Institutions and Human Rights (ODIHR). The programme included a series of seminars, debates and other events, where the European preventive mechanisms exchanged experiences between them and with other relevant civil society organisations on the prevention of torture, inhuman and degrading treatment in a European context.



Member of the UN Subcommittee on Prevention of Torture (SPT), Victor Zaharia, reads the Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons with interest.

APT is an important resource for NPM's throughout the world and helps to ensure international knowledge transfer on preventing torture, inhuman or degrading treatment. In 2019, the NPM participated in APT's sounding board for the development of a toolkit for NPMs.

Statistics

Number of visits in 2019, per sector

SECTOR	NUMBER
Mental health care	2
Child welfare	10
Total	**12**

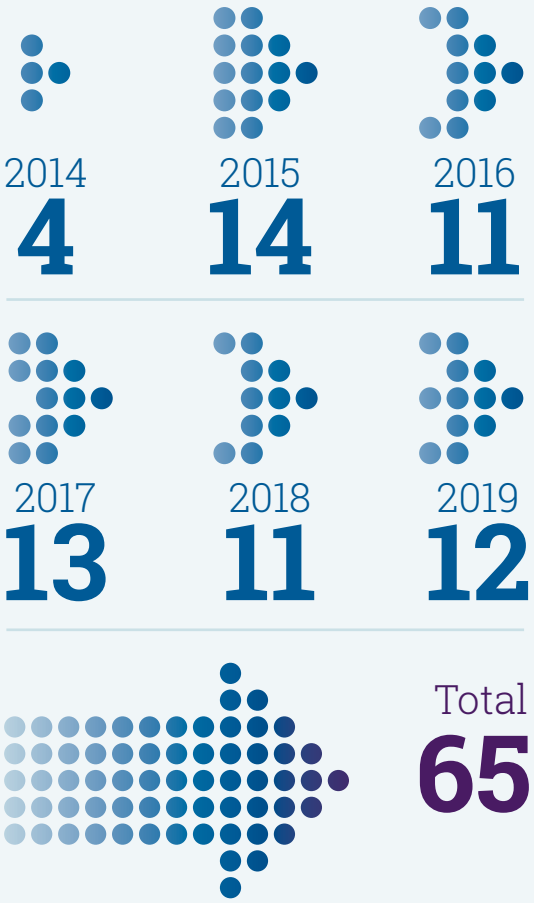
External activities

20 lectures and talks

34 meetings with national stakeholders

10 meetings with international partners

Number of places visited since start-up, per year



Visits in 2019

	DATE OF VISIT	PLACE	SECTOR	DATE OF PUBLICATION OF VISIT REPORT	PARTICIPATION OF EXTERNAL EXPERT
1	20–21 May	Buskerud and Vestfold Emergency Youth Centre, Barkåker	Child Welfare Service	16 October	No
2	4–6 September	Two sections at Humana Child Welfare Service East: Section Jessheim and Hol farm	Child Welfare Service	20 November	No
3	25–26 September	Jong Youth Centre	Child Welfare Service	Will be published in 2020	No
4	8–10 October	Three sections at Stavanger University Hospital: Child and Adolescent Psychiatry Units	Mental health care	Will be published in 2020	No
5	12–14 November	Six units at Stendi Region North, Nymogården	Child Welfare Service	Will be published in 2020	No

Activities in 2019

Lectures, talks, teaching and participation in panels in Norway

WHEN	ACTIVITY
10–13 January	Talk at the KROM (Norwegian Association for Penal Reform) conference on legal safeguards in prisons.
17 January	Panel in connection with the launch of the legal aid organisation for women's (JURK) prison survey among female inmates in Norwegian prisons.
31 January	Introduction to and participation in the panel during the event on solitary confinement of prisoners requiring medical treatment in Norwegian prisons in Bergen. Organised by Jussgruppen Amnesty and the International Commission of Jurists' (ICJs) student network in Bergen.
18 March	Lecture to trainees at the Correctional Service of Norway Staff Academy (KRUS).
26 March	Lecture to the trainees at KRUS.
28 March	Seminar to launch the annual report 2018. Debate on forced medication.
1–2 April	Talk on the NPM's work in prisons during the annual national criminal law conference in Loen.
11 April	Talk on the use of coercion against children in institutions, the Norwegian Bar Association's Human Rights Seminar.
7 May	Talk for Red Cross volunteers visiting the police immigration detention centre at Trandum.
21 May	Talk on the Parliamentary Ombudsman's visits to the Office for Children, Youth and Family Affairs' (Bufetat) institutions at its management conference.
21 May	Lecture for police custody officer managers about the Parliamentary Ombudsman's findings and experience from visits to police custody facilities.
12–15 August	Arendalsuka (political festival). The NPM organised a panel debate on solitary confinement in Norwegian prisons and participated in 34 events of direct relevance to its preventive work.
23 August	Opening talk during Amaliedagene 2019 (mental health festival).
13 September	Panel discussion on solitary confinement and prison reform, the University of Oslo (UiO).
25 September	Talk at Isolasjonskonferansen (solitary confinement conference), organised by KRUS and the Directorate of Correctional Service.
16 October	Talk for Lovisenberg behandlergruppe (therapist group) about the NPM's work.
8 November	Talk at the Supervisory Commission Conference.
27 November	Talk at Lucy Smith's Children's Rights Day, organised by UiO and the Ombudsman for Children.
12 December	Talk during the celebration of Professor Nora Sveaass 70th birthday, UiO.
13 December	Lecture for psychologists specialising in the introductory programme, the Norwegian Psychological Association.

Meetings, visits and participation at seminars in Norway

WHEN	ACTIVITY
25 January	Forandringsfabrikken's launch of the report: *Hvis jeg var ditt barn. Om tvang i barnevernsinstitusjon* (If I were your child. On the use of coercion in child welfare institutions).
5 February	Ombudsman network meeting at the offices of the Equality and Anti-Discrimination Ombudsman.
11 February	Meeting with the advisory committee to the National Preventive Mechanism.
13 February	Meeting with the advisory committee to the Norwegian National Human Rights Institution (NIM).
18 February	Forandringsfabrikken's launch of the report: *Hvis jeg var ditt barn. Om tvang i psykisk helsevern.* (If I were your child. On the use of coercion in psychiatric health care).
25 February	Meeting with the management of Lovisenberg Diaconal Hospital, mental healthcare clinic on a project on reducing the use of coercion.
6 March	Seminar at the Ombudsman for Children's offices on the topic 'Ungdomskriminalitet – straff som virker?' (Youth Crime – what punishment works?').
13 March	Meeting with Forandringsfabrikken.
27 March	Submission and presentation of the annual report 2018 to the Storting's Standing Committee on Scrutiny and Constitutional Affairs.
15 May	Meeting with the Office for Children, Youth and Family Affairs (Bufetat) Region East on their work on safety and security in institutions.
22 May	Round table conference on the best interests of the child upon detention. Organised by the Norwegian Police Immigration Service (NPIS).
22 May	Meeting with the advisory committee to the Norwegian National Human Rights Institution.
3 June	Meeting of the advisory committee to the National Preventive Mechanism, with a visit from the Norwegian Board of Health Supervision, which gave a talk on the nationwide supervision of child welfare institutions in 2018.
18 June	Submission and presentation of the Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons (the Special Report) to the Standing Committee on Scrutiny and Constitutional Affairs.
21 June	Annual meeting with the Ministry of Justice and Public Security.
21 August	Meeting with the Directorate of the Norwegian Correctional Service on the Special Report.
21 August	Meeting with lawyer Maria Hessen Jacobsen on solitary confinement in Norwegian prisons.

WHEN	ACTIVITY
26 August	Meeting with the Ministry of Health and Care Services on the Special Report and the thematic report on segregation in mental healthcare institutions.
28 August	Presentation of Norwegian Official Report 2019:14 Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven] by the chair of the authoring committee (Tvangslovsutvalget), professor at the Faculty of Law at the University of Bergen, Bjørn Henning Østenstad.
20 September	Celebration of Nora Sveaass' receipt of the King's Medal of Merit.
10–11 October	Attended the Institution conference 2019. Topic: Samhandling i miljøterapien – vekst og utvikling for og med barn og ungdom (Interaction in milieu therapy – growth and development for and with children and young people).
14 October	Meeting of the advisory committee. Nora Sveaass gave an introductory talk on the work of the UN Subcommittee on the Prevention of Torture.
15 October	Meeting with the Red Cross on solitary confinement in prisons and the project on the rehabilitation of victims of torture in Norway.
16 October	Meeting of the ombudsman network, the Norwegian National Human Rights Institution (NIM), the Equality and Anti-Discrimination Ombudsman (LDO) and the Ombudsman for Children.
17 October	Meeting with the Directorate of the Norwegian Correctional Service's labour association on the Special Report to the Storting.
23 October	Meeting with the Directorate of Health on the Special Report to the Storting.
1 November	Meeting with the Norwegian Nurses' Association on the Special Report.
5 November	Meeting with the interim board for the establishment of a human rights committee in the Norwegian Medical Association.
26 November	Meeting with the Standing Committee on Justice, at the Storting on the Special Report to the Storting.
10 December	Meeting with the Norwegian Board of Health Supervision on the Special Report.
10 December	Meeting with the Standing Committee on Health and Care Services, at the Storting, on the Special Report to the Storting.
11 December	Meeting with the advisory committee to the Norwegian National Human Rights Institution.
13 December	Meeting with the Ombudsman for Children about key findings in its report on child welfare institutions, to be launched in January 2020.
18 December	Meeting with the Socialist Left Party's parliamentary group on the Special Report to the Storting.

Meetings and visits from abroad

WHEN	ACTIVITY
14 March	Meeting with the organisation Prison-Insider, represented by Carolina Nascimento. The NPM provided input on the development of the organisation's information page about Norway.
14 May	Meeting with a delegation from the state of Louisiana, United States, which is working to improve prison conditions in the state. The delegation represented universities, non-governmental organisations and local authorities, and they were particularly interested in supervisory arrangements and control of prison operations.
20 June	Meeting with Professor Steve Chanenson, Villanova University Charles Widger School of Law. Professor Chanenson is involved in a research team that works with the Directorate of the Norwegian Correctional Service (KDI) and Pennsylvania Department of Corrections.
9 October	Meeting with the UN Special Rapporteur on the rights of persons with disabilities. Meeting with the ombudsman about the visit of the Rapporteur to Norway.
1 November	Talk on the NPM's work and methods for a delegation from the Vera Institute of Justice, Center of Sentencing and Corrections from New York, United States.

Meetings and visits abroad, participation in international conferences etc.

WHEN	ACTIVITY
9 January	Seminar and panel discussion on improving NPMs' supervision methods at DIGNITY, Copenhagen, Denmark.
24 January	Meeting of the Nordic NPM network in Helsinki, Finland. Focus on elderly care and people with disabilities.
7 March	Video conference with the European NPM network.
29 August	Meeting of the Nordic NPM network in Reykjavik, Iceland. Focus on ethical dilemmas in treatment, in particular the balance between the right to privacy and security.
4–5 November	Meetings in Strasbourg, France, on occasion of the European Committee for the Prevention of Torture's (CPT) 30th anniversary and meetings of the European NPM network.

Budget and Accounts 2019

CATEGORY	BUDGET 2019	ACCOUNTS 2019
SALARY	8 135 000	7 394 071
OPERATING EXPENSES		
Production and printing of visit reports, annual reports and information material	410 000	582 273
Purchase of external services (including translation and interpreting services)	190 000	366 668
Travel (visits and meetings)	445 000	314 882
Other operating expenses	350 000	394 970
Share of the Parliamentary Ombudsman's joint costs (including rent, electricity, IT services, security, cleaning etc.)	1 970 000	1 983 343
TOTAL NOK	**11 500 000**	**11 036 207**

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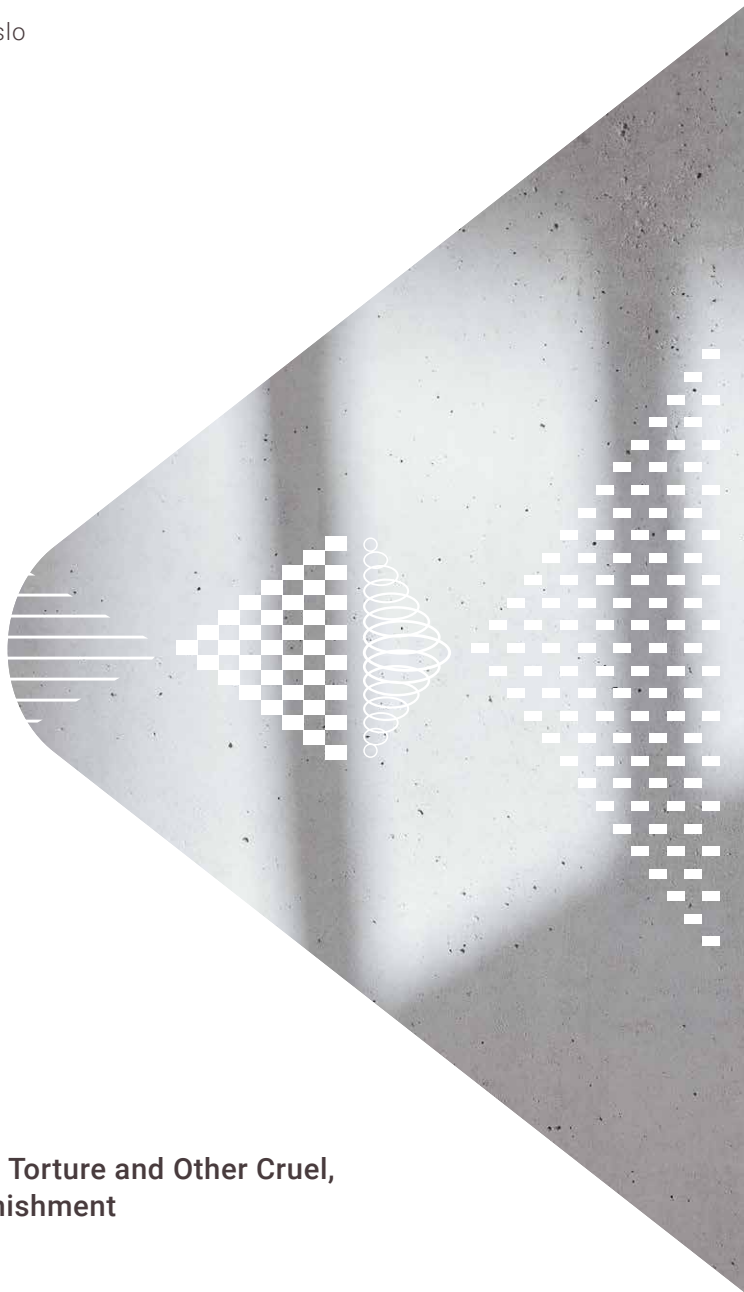

National Preventive Mechanism against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment