



SIVILOMBUDSMANNEN

Norwegian Parliamentary Ombudsman
National Preventive Mechanism

VISIT REPORT

Bergen police custody facility

25 January 2016



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1 The Parliamentary Ombudsman's preventive mandate

Based on Norway's ratification of the Optional Protocol to the UN Convention against Torture (OPCAT), the Parliamentary Ombudsman has been issued with a special mandate to prevent torture and other cruel, inhuman or degrading treatment or punishment.¹ The Parliamentary Ombudsman has established its own National Preventive Mechanism (NPM) in order to fulfil this mandate.

The NPM makes regular visits to locations where people are deprived of their liberty, such as prisons, police custody facilities, mental health care institutions and child welfare institutions. The visits may be announced or unannounced.

Based on these visits, the NPM issues recommendations with the aim of preventing torture and other cruel, inhuman or degrading treatment or punishment. The Parliamentary Ombudsman, represented by the NPM, has right of access to all places of detention and the right to speak privately with people deprived of their liberty. The NPM also has right of access to all essential information relating to detention conditions. During its visits, the NPM will seek to identify risks of violation by making its own observations and through interviews with the people involved. Interviews with detainees are given special priority.

The NPM also engages in extensive dialogue with national authorities, civil society and international human rights bodies.

¹ The Act relating to the Parliamentary Ombudsman for Public Administration Section 3(a).

2 Summary²

The Parliamentary Ombudsman's National Preventive Mechanism (NPM) visited West Police District's custody facility at Bergen police station on 25 January 2016. The visit was unannounced. The custody premises contained 27 cells.

During the visit, the police's procedures for preventing serious incidents in the custody facility were reviewed. The available information indicated that the police had satisfactory procedures for assessing detainees' condition at the time of detention. It was emphasised that the police had a formal arrangement that ensures a good information flow between the custody facility and the prison in connection with the transfer of remand inmates if there is a risk of suicide or other special circumstances.

The NPM looked at what means of restraint were available at the custody facility and the procedures for using them. Written procedures were lacking for the use of handcuffs in connection with transport assignments. The police district also had access to a BodyCuff restraint system,³ which is occasionally used at the custody facility to prevent self-harm. No complete overview existed of the use of this system, however.

The NPM looked at the police's efforts to prevent solitary confinement during stays in the custody facility. The use of solitary confinement is an invasive measure that must be strictly necessary in each individual case. The police had not implemented sufficient measures to prevent solitary confinement where such a measure was not warranted. The challenges are primarily due to the fact that the custody facility building is not designed for human interactions. To avoid systematic violations of European Convention of Human Rights (ECHR) Article 8, building alterations appear to be needed.

During its visit, the NPM examined the police's efforts to meet the time limit for transferring detainees from the police custody facility to a prison within two days of their arrest. It was positive that the number of breaches of the time limit seemed to be decreasing. Long-term stays in the custody facility had been reduced because it was decided more often to release detainees. At the same time, it gave cause for concern that so many detainees still spent more than two days in the custody facility. There is therefore a need to intensify the work on preventing breaches of the time limit, especially in cases involving foreign nationals, where breaches occur more frequently.

The police practice is that detainees are routinely escorted to the municipal accident and emergency unit. It was positive that the police had a low threshold for contacting the health service. The challenge was that medical personnel were asked to confirm that the person in question could be placed in custody, and that, in practice, the doctors approved the stay by signing a form. This practice seems questionable from a medical ethics perspective, and it may undermine the relationship of trust between patients and medical personnel and reduce the quality of the health services provided. The role of medical personnel shall be limited to treating the detainee as a patient. Approval of detention in a custody facility does not fall under their professional remit.

² Read the full report in Norwegian on the Parliamentary Ombudsman's website: <https://www.sivilombudsmannen.no/visit-reports-2016/category3084.html>.

³ A BodyCuff consists of hand and foot cuffs connected to a hip belt by straps that enable the degree of freedom of movement to be adjusted.

The custody log did not adequately document whether measures had been implemented to prevent torture and ill-treatment, such as information about rights on arrival, the possibility of notifying next of kin and contacting a defence counsel. The custody log did not provide sufficient documentation of the police's efforts to prevent breaches of the time limit, of the carrying out of supervisory activities or individual assessments of the need for solitary confinement.

An inspection revealed that the cells in the custody facility were poorly suited to treating detainees humanely. The fact that some of the cells were very small and that they neither had access to daylight nor a clock gave particular cause for concern. Three of the cells that were inspected were between four and five square meters in size. Using such small cells for detention overnight appears to be an unfortunate practice.

Recommendations

Incidents and means of restraint

Serious incidents

- The police should tighten up their procedures for entering the results of detainee checks in the custody log, with the focus on the detainee's breathing rate and body position.

Use of means of restraint

- Written guidelines should be established for the use of all available means of restraint during stays in the custody facility and in connection with transport assignments, including the use of handcuffs, BodyCuff, truncheons and pepper spray.
- All use of means of restraint in custody facilities and in connection with transport assignments should be documented in the custody log, and statistics should be prepared on the use of each type of restraint.

Body searches

- Clear procedures should be established for risk assessments and for how to carry out body searches. If, based on an assessment in each case, complete removal of clothing is deemed to be necessary, the measure should be carried out in two steps to avoid the detainee being completely naked.

Solitary confinement in police custody

Preventing isolation

- Effective measures should be implemented that prevent detainees from being isolated if this is not strictly necessary in the interest of public safety.
- It should be ensured that an assessment is made of whether it is necessary to place individual detainees in solitary confinement, and that this assessment is entered in the custody log.

Time in detention

- The police should intensify their efforts to meet the time limit for transferring detainees from custody to prison, especially in cases involving foreign nationals.
- The police should ensure that all requests for prison places and the outcome of such requests are recorded in the custody log. The grounds for any breach of the time limit should always be entered in the custody log.

Children in detention

- In consultation with the child welfare emergency unit, the police should establish procedures for informing the unit about all cases where minors have been apprehended and brought in.

Health services

Confidentiality

- It should not be possible for the police to hear what is being said in the patient room. Nor should it be possible for the police to see what is taking place in the patient room, unless the medical personnel so request in special cases.

Professional independence

- The accident and emergency unit should ensure that it never conducts medical examinations that are, or are perceived as, approval of detention in the police custody facility. The police should help to prevent such a view spreading among the detainees.

Information and notification

Information about rights

- The police should ensure that all detainees are informed in writing and verbally about their rights as detained or apprehended persons as soon as possible after being detained, and that this is documented in the custody log.
- The police should establish procedures to ensure that all detainees are asked to sign a declaration that they have been informed about their rights in a language they understand.

Notification of next of kin

- The police should ensure that efforts to notify next of kin or third parties are documented in the custody log. Where notification is delayed in order not to hamper the investigation, this should be recorded in the custody log.

Notification of defence counsel

- The police should ensure that contact with or attempts to contact defence counsel are always documented in the custody log.

- The police should ensure that the information material on rights in connection with apprehension is updated to make it clear that the duty to notify a defence counsel applies regardless of the time of day.

Documentation in custody log

- The police should implement measures to ensure sufficient and clear documentation in the custody log of compliance with the detainees' rights.

The building

The cells

- The use of cells smaller than five square meters in size should be avoided, especially for detention overnight.
- All cells should have clocks installed.

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