ÅLESUND POLICE CUSTODY FACILITY

Report Summary and Recommendations from the National Preventive Mechanism's Visit to Ålesund Police Custody Facility[1]

11 March 2015

The Parliamentary Ombudsman's preventive role

After Norway's ratification of the Optional Protocol to the Convention against Torture (OPCAT) in the summer of 2013, the Parliamentary Ombudsman was given a mandate to prevent torture and other cruel, inhuman or degrading treatment or punishment.[2] To fulfil this mandate, a special unit called the National Preventive Mechanism (NPM) was established in the Parliamentary Ombudsman's office.

Representatives of the NPM make regular visits to locations where people are deprived of their liberty, such as prisons, police custody facilities, psychiatric institutions and child welfare institutions. The visits may be announced or unannounced.

On the basis of these visits, recommendations are issued with the aim of preventing torture and other cruel, inhuman or degrading treatment or punishment.

The Parliamentary Ombudsman, through the NPM, is authorised to enter all places of detention and to engage in private conversations with those who have been deprived of their liberty. The NPM also has access to all essential information relating to detention conditions. Through independent observation and dialogue conducted during its visits, the NPM seeks to uncover risk factors that could open the way for abuses to occur. Conversations with persons deprived of their liberty are given special priority.

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

Summary

On 11 March 2015, the Parliamentary Ombudsman's National Preventive Mechanism (NPM) made a visit to Ålesund Custody Facility. The facility has status as primary custody facility in Sunnmøre Police District and has ten cells in all. The visit was unannounced. The NPM's general impression is that the custody facility is administered and run in a sound manner.

During its visit, the NPM examined the police's handling of serious incidents and use of coercive measures. There had been no recent suicides at the custody facility, but several attempted suicides had been prevented during the past six months. On the whole, the procedures for physical supervision were satisfactory. A document review revealed that the results of the supervision of detainees at risk could be better documented, however.

[1] You can find the full visit report in Norwegian on the NPM's website: https://www.sivilombudsmannen.no/reports/category2967.html.
[2] The Parliamentary Ombudsman Act § 3a.

The existing information indicates that the police have clear procedures for the use of handcuffs, and that body searches are carried out based on an assessment in each case by an officer of the same gender. It was nevertheless recommended to improve the procedures for carrying out body searches.

The number of breaches of the police custody holding period has been relatively low in Sunnmøre Police District in recent years, even though the figures vary significantly. Nevertheless, a review of cases where the holding period exceeded two days (48 hours) showed inadequate documentation of measures to procure prison places. It is important to start the work of procuring prison places as early as possible and to document the actions taken. The available information indicates that the police implement accommodating measures to alleviate the effects of isolation, particularly in the form of frequent trips to the exercise yard, including, by way of exception, in the company of other detainees.

An investigation was carried out of whether the detainees' right to receive medical help was observed. It is good that the police seem to have a low threshold for escorting detainees to the accident and emergency unit, but this entails stringent requirements for medical personnel to be aware of their role. The only task of medical personnel is to examine the patient's health status. Where health examinations are initiated by the police, there is an increased risk that the examinations are converted to conveyor belt decisions with a shift in focus from examination of the patient to 'clearance for remanding in custody'. This can cause other health needs that the patient might have to be overlooked, and may undermine the relationship of trust between the patient and medical personnel.

It was found during the visit that both the police and the accident and emergency unit should do more to prevent a confusion of their roles. A review of the custody logs revealed examples of inmates having been 'examined by a doctor as okay for continued remand in custody'. Interviews with the accident and emergency unit's management indicated that health examinations of escorted detainees were perceived as expert assignments in which the police were seen as the client. This is an unfortunate state of affairs. The accident and emergency unit also lacks a procedure for dealing with suspected disproportionate use of force or injuries to detainees caused by the police.

It was also pointed out that the police could improve their procedures for ensuring that detainees are informed about their rights at the earliest opportunity. It was evident that, in several instances, the detainees were not informed about their rights until the day after being detained.

The NPM conducted an inspection of the custody premises. It was pointed out that the air quality was highly unsatisfactory in several of the cells and that immediate action should be taken to improve the air quality. The cells were painted in a heavy grey colour and most of the cells lacked adequate colour contrast between the floor and walls. Furthermore, the lack of access to a clock and daylight makes time orientation difficult for the detainees. The available information indicates that the detainees are offered to spend time outdoors every day. The NPM also recommended some minor building alterations to prevent people being able to see the outdoor area from the outside.

Based on its visit, the National Preventive Mechanism finds that there are grounds for issuing the following recommendations:

• The police should establish procedures for entering the results of supervisions of detainees at risk in the custody log, with the focus on the detainee's breathing rate and body position.

• The police should amend local instructions to make it clear that only detainees at risk are to be supervised every half hour.

• Where, 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 leaving the detainee completely naked.

• The procurement of suitable rip-resistant clothing should be considered where a concrete risk of suicide is found to exist. The detainee should not be left naked in the custody facility.

• 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 holding period should always be entered in the custody log.

• The police should ensure that special measures in connection with the detention of juveniles in the custody facility are documented in the custody log in accordance with the National Police Directorate's guidelines.

• The police should continue their effort to alleviate the unfortunate effects of isolation, particularly by considering the possibility of receiving external visitors in the case of detainees who have remained in custody for more than two days.

• The police should ensure that assessments are carried out from a prosecution perspective of whether the need for isolation is present in each case and ensure that the assessment is entered in the custody log.

• The police should not be able to listen in on what is being said in the patient room. Nor should the police be able to observe what is taking place in the patient room, unless this is requested by the medical personnel in special cases.

• The accident and emergency unit should ensure that it never conducts medical examinations that are, or are perceived as, an approval of the remand in custody. The police should help to prevent such a view from gaining a foothold among the detainees.

• The accident and emergency unit should have a camera available so that any injuries to detainees can be documented by the doctor in the patient records.

• The police should ensure that all detainees are informed in writing and verbally about their rights as admitted or apprehended persons as soon as possible after being detained.

• 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.

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

• The police should remove the metal rings that are attached to the wooden bench in the reception room.

• The police should take immediate action to ensure satisfactory air quality in all the cells and to achieve colour contrast between the floor and walls to make it easier for the detainees to maintain a sense of direction.

• It is recommended that the police explore the possibility of upgrading the cells to give them a more humane design. All cells should have clocks installed.

• The police should consider making building alterations to prevent the general public from being able to see into the atrium, though not at the expense of access to daylight.

• The police should ensure that all offers to spend time outside are logged in the custody log, also when detainees choose not to avail themselves of the offer.