SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

Oslo University Hospital, psychosis treatment unit, Gaustad

17.-19 October 2017

National Preventive Mechanism against
Torture and Ill-Treatment

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1 The Parliamentary Ombudsman's prevention mandate

As a result of Norway's ratification of the Optional Protocol to the UN Convention against Torture in 2013, the Parliamentary Ombudsman was 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 regularly visits locations where people are deprived of their liberty, such as prisons, police custody facilities, mental health care institutions and child welfare institutions. The visits can be both announced and unannounced.

The Parliamentary Ombudsman has 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 Parliamentary Ombudsman also has right of access to all necessary information that is relevant to the conditions for people deprived of their liberty.

The risk of torture or ill-treatment occurring is influenced by factors such as legal and institutional frameworks, physical conditions, training, resources, management and institutional culture.[2] Effective prevention work therefore requires a broad approach that does not exclusively focus on whether the situation complies with Norwegian law.

The Parliamentary Ombudsman's consideration of factors that constitute a risk of torture and ill-treatment is based on a wide range of sources. During its visits, the Ombudsman examines the conditions at the institution through its own observations, interviews and a review of documentation. Private interviews with those who are deprived of their liberty are a particularly important source of information, because they have first-hand knowledge of the conditions at the institution in question. They are in a particularly vulnerable situation and have a special need for protection. Interviews are also conducted with the staff, management and other relevant parties. Documentation is also obtained to elucidate the conditions at the institution, such as local guidelines, administrative decisions on the use of force, logs and health documentation.

After each visit, the Parliamentary Ombudsman writes a report describing its findings and recommendations for preventing torture and other cruel, inhuman or degrading treatment or punishment.

The reports are published on the Parliamentary Ombudsman's website and the institutions visited are given a deadline for informing the Ombudsman about their follow-up of the recommendations. These letters are also published.

In its endeavours to fulfil the prevention mandate, the Parliamentary Ombudsman also engages in extensive dialogue with national authorities, control and supervisory bodies in the public administration, civil society and international human rights bodies.

[1] Section 3 a of the Parliamentary Ombudsman Act.

[2] 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/30/6.

2 Summary

The Parliamentary Ombudsman's National Preventive Mechanism (NPM) visited Oslo University Hospital (OUS), psychosis treatment unit, Gaustad on 17–19 October 2017. The hospital was notified in advance that the Parliamentary Ombudsman was planning a visit, but the date of the visit was not announced.

The unit comprised three inpatient units, two of which were local high-risk psychiatric units and one was a psychosis unit. The three units were located in old, run-down premises. The segregation units in the high-risk psychiatric units appeared to be in very poor condition. The segregation unit at the psychosis unit comprised one bare, prison-like room, and no other common rooms. There were separate rooms with restraint beds bolted to the floor in all of the segregation units, and there were several such rooms in each segregation unit at the high-risk psychiatric units.

There appeared to be a good range of activities on offer, but most of them were in other buildings than those that housed the units. This created challenges when the patients were subject to restrictions on being outdoors and not enough staff were on duty to accompany them to such activities. A fenced-in outdoor area had been built behind the building that housed the two high-risk units, where patients subject to restrictions could get some fresh air. The area was large and undulating and suitable for various outdoor activities. Trees had been planted to reduce visibility from the driveway, but, it was still, at that point, possible to see into the whole area from the road.

At the time of the visit, no errors were found in administrative decisions concerning the use of mechanical restraints or other use of force, as has been the case previously. The written grounds for decisions concerning the use of segregation and being placed in restraints were not routinely given to patients. New templates for administrative decisions pursuant to the legal amendments made in 2017 appeared, however, to ensure that the grounds were also given to the patients, as the grounds are now included in the decision itself.

There is a practice whereby it is possible to delay a patient's access to his/her own record at the high-risk psychiatric units, out of consideration for the safety of the staff. A note on the work computers at one of the high-risk units was worded in a way that could give the impression that the patients could be denied all access to their records. Some patients said that they had not been given access to records or administrative decisions, allegedly because the staff had forgotten and then the patient had forgotten about it themselves.

The unit had a relatively low prevalence of the use of mechanical restraints, and had focused in recent years on preventing their use. Findings made during the visit indicated that the employees received training and refresher training in ensuring that restraints were used in the safest and gentlest way possible. The mental health professional responsible for administrative decisions performed evaluations with patients after restraints were used. It emerged during the visit that employees occasionally placed a towel over a patient's face in the event of spitting in connection with restraints. There were also examples of patients sleeping in restraints, and it emerged that mobile restraints had previously been used when patients went outdoors to smoke if they were considered to pose an escape risk.

Some misunderstandings emerged during the visit about what constitutes isolation pursuant to the Mental Health Care Act, and that administrative decisions were not made in every case of short-term holding.

Many patients had experience of being segregated, and segregation was perceived by the patients as the primary coercive measure in use at the unit. Findings made during the visit and from the review of documentation indicated that segregation was often of a short duration, sometimes for just a few hours or 1-2 days in other cases. Segregation appeared to be carried out in a flexible manner, and the staff were aware that it may have harmful effects on or distress the patient. Some of the patients in the ordinary parts of the units could be subject to 'agreements' that required them to spend long periods in their rooms during the course of the day. It varied whether a segregation decision had been made when such day plans were used, although the patients felt they had little say in these 'agreements'. In some cases, the patients were alone in the segregation unit, while the staff sat outside a closed glass door in the ordinary section beside one of the high-risk units.

At the psychosis unit, segregation was primarily carried out in the patients' own rooms rather than using the segregation unit, as it was regarded as being unsuitable for longer stays. Segregation in patients' own rooms at the psychosis unit could entail patients spending long periods of time in their rooms, without contact with the staff.

There has been an increase in the number of administrative decisions concerning forced medication at the unit in the past year. The extent to which the patients felt that they had received sufficient information about the effects and possible side-effects of the medication varied. Administrative decisions concerning forced medication contained very thorough grounds, but the actual conditions on which the intervention was based were not well-enough or specifically described in many of the decisions. New templates for administrative decisions pursuant to the legal amendments in 2017 ensured this was addressed to a greater extent.

Findings made during the visit indicated that visit control was occasionally practised through employees being present in the visit room, without consideration being given to whether the strict conditions for such control pursuant to Section 4-5 of the Mental Health Care Act were met. Some patients also described how they were not allowed visits from various people, again without administrative decisions being made.

The unit routinely carried out body searches of patients after they had been outside the units. Interviews with patients indicated that body searches were carried out in a respectful manner, although some patients found such established control measures distressing.

Findings from the visit indicated that there had previously been some concern about the supervisory commission's work at the unit. At the time of the visit, the head of the supervisory commission had recently been replaced, and new procedures were described for addressing case processing and regular reviews of patients' overall situation. Notices were posted in all units with contact information for the various complaint bodies.

Many of the patients in the units described being treated with respect and dignity by the staff, and said that they felt their personal security was addressed during admission. Many of the employees were highly skilled and had high ethical standards, and appeared to be well-trained in keeping antagonistic communication with patients at a minimum.

At the time of the visit, an active user council with good knowledge of the unit was not in place, and the patients or other user representatives did not appear to be involved in systematic or planning work at the unit.

The following recommendations are made on the basis of the NPM's visit:

Recommendations

- The hospital should implement measures, at all segregation units in particular, which ensure that the physical conditions maintain the patients' dignity and reflect respect for the patients.
- The hospital should consider the design of the segregation unit in Psychosis Unit 3 to protect patients from the risk of isolation and harmful sensory deprivation.
- Restraint beds should not be placed in the segregation unit.

Recommendation

- The section should maintain its focus on providing the best possible range of activities to all patients, including those subject to restrictions on being outdoors.

Recommendation

- The section should ensure that patients receive written administrative decisions with the grounds for the coercive measure unsolicite
- The section must make it clear to the staff that all patients are entitled to access to their records, and inform them of the restrictions that apply if delayed access is in force for security reasons.

Recommendation

- The mouth or face of restrained patients should never be covered.
- Action should be taken to ensure that decisions to use coercive measures are revoked as soon as the risk of harm is no longer present.

Recommendation

- The section should review its practice of rest times in agreement with patients to ensure that segregation decisions are written in instances where the agreements curtail the patients' right to autonomy.
- Action should be taken to ensure that patients are not segregated in a way which in reality is equivalent to isolation.

Recommendation

- The section should implement measures to ensure that the person responsible for an administrative decision systematically considers whether all the statutory conditions are met when making an administrative decision on the use of force.
- Administrative decisions on the use of force should always contain concrete grounds that make it possible to see how the statutory conditions have been taken into account in the case at hand.

Recommendation

- Action should be taken to ensure that visit control or refusal of visits should only be implemented if the statutory conditions are met and the decision is recorded.

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