SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

# Bergen Prison

2-4 May 2018


National Preventive Mechanism against
Torture and Ill-Treatment

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# 1 The Parliamentary Ombudsman's prevention mandate

Norway endorsed the Optional Protocol to the UN Convention against Torture in 2013. The Convention obliges states to establish bodies to protect persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment.[1] The Parliamentary Ombudsman was assigned this task, and the National Preventive Mechanism (NPM) was established in order to perform this duty.

The Parliamentary Ombudsman has access to all places where people are deprived of their liberty and access to all information of relevance to the conditions under which people are deprived of their liberty. The National Preventive Mechanism (NPM) makes regular visits to facilities 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 risk of torture or inhuman 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 inhuman treatment is based on a wide range of sources. During its visits, the NPM examines the conditions at the institution through 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 right to protection in connection with the interviews. 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, records 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/12/6.

# 2 Torture and inhuman treatment

The prohibition on torture and other cruel, inhuman or degrading treatment or punishment is established in a number of international conventions that are binding on Norway.

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture), adopted in 1984, plays a central role in this work. The same prohibition is enshrined in the UN International Covenant on Civil and Political Rights (Article 7), the UN Convention on the Rights of the Child (Article 37), the UN Convention on the Rights of Persons with Disabilities (Article 15), and the European Convention on Human Rights (Article 3). Norway has endorsed all these conventions.

People who have been deprived of their liberty, are vulnerable to violations of the prohibition against torture and inhuman treatment. That is why the UN adopted an Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 2002. Norway endorsed the Optional Protocol in 2013.

# 3 Summary

The Parliamentary Ombudsman's National Preventive Mechanism (NPM) made a visit to Bergen Prison on 2-4 May 2018. The date of the visit was not announced in advance. The visit was part of the follow-up of the Parliamentary Ombudsman's report following its previous visit to Bergen Prison in 2014. The main purpose of the visit in 2018 was to investigate the prison's practices in connection with exclusion from company and time spent outside the cells.

Bergen Prison is Norway's second largest prison and has an ordinary capacity of 281 places, divided between 218 high security places and 63 lower security places. The NPM's visit did not include the prison's lower security section.

Bergen Prison has three security cells in section A-vest. The Parliamentary Ombudsman found that the prison's security cells bore signs of wear and tear, and that the size of the smallest cell bordered on the European Committee for the Prevention of Torture's (CPT) minimum recommendations. The calling system in the cells did not work. The fact that inmates in security cells are unable to contact the prison officers is a matter of grave concern. The lights were also on in the cells all day and night with no possibility of dimming them.

Administrative decisions concerning the use of security cells were generally of a satisfactory quality. However, the fact that several administrative decisions concerning placement in security cells were regulated by Section 38 (c) of the Execution of Sentences Act, which is not permitted pursuant to the Directorate of Norwegian Correctional Service's guidelines to the Execution of Sentences Act, is a matter of concern.

Bergen Prison made six administrative decisions concerning the use of security cells in the case of two juvenile inmates in the course of 2017. The use of security cells for juvenile inmates is a highly invasive measure that is potentially very harmful. A review of the administrative decisions and records gave the impression that the prison had not implemented satisfactory procedures to safeguard juvenile inmates in security cells.

A review of records from 2017 showed that security cells were used in a total of 15 instances to prevent suicide or self-harm. This represents 24 per cent of all detentions in security cells. Four of nine placements in security cells between January and May 2018 were made to prevent suicide or self-harm. The prison administration stated that a shortage of resources, which meant it was not possible to provide supervision during the evening and night shifts in the ordinary sections, was a contributing factor to placement in holding cells or security cells.

The restraint bed had been used once in the course of 2016 and once in 2017 at Bergen Prison. The incident in 2016 concerned a minor. In light of the information received by the Parliamentary Ombudsman, it is of grave concern that the minor was placed in a restraint bed, and that the measure was maintained over a relatively long period of time.

There were 24 cells in total in section A-vest, in addition to three security cells and five holding cells. During the visit, members of staff and inmates stated that women were occasionally placed in the restrictive section A-vest if there were no available places in the women's section in section C, and that women could not be placed in the intake department A-øst. It is a matter of grave concern that women are placed in this section due to a lack of places and resources.

Many complained of too much isolation and a lack of activity in section A-vest. Reference was made to the fact that the prison's staff resources and the time allocated to each inmate had consistently worsened compared with the Parliamentary Ombudsman's visit in 2014.

Section A-øst was established in 1999 to meet the need for more remand places. However, the section also receives convicted inmates pending a place becoming available in another section, and inmates who, for various reasons, cannot or do not want to be in the communal section. The are 53 cells in section A-øst.

In order to improve the activity programme in the section, an activity room was built in 2016. Due to the large number of inmates in the section, access to the room was limited. Although the inmates have a better activity programme than was the case during the 2014 visit, the section is still characterised by extensive use of isolation. During the visit, it emerged that only one of the inmates in section A-øst had received an administrative decision regarding exclusion from company. The fact that administrative decisions had not been made regarding the exclusion of inmates, whose only activity option, in practice, was to spend time in the exercise yard three of seven days a week, appears to be in breach of Section 17 of the Execution of Sentences Act. It is deemed to be even more serious that this type of practice, which means that inmates are locked in their cells for a minimum of 22 hours for four out of seven days, counts as being placed in the communal section. This means that inmates placed in a communal section in Norway, are in fact serving under conditions that correspond to isolation by international standards. The Parliamentary Ombudsman will follow this up in dialogue with the Directorate of the Norwegian Correctional Service and the Ministry of Justice and Public Security.

It emerged during the visit that there were regularly inmates at Bergen Prison with such severe mental disorders and low level of functioning that they were generally unable to be part of the ordinary prison community. These inmates risked being excluded from section A-vest for long periods of time. In addition, there were several inmates who, due to mental disorders, among other things, chose to isolate themselves in section A-øst. The Parliamentary Ombudsman takes a very serious view of the situation in which individuals with mental health problems are subject to long-term exclusion. The Norwegian authorities have a duty to ensure that inmates with mental disorders who are detained in prisons are not subjected to degrading or inhuman treatment.

During the visit in 2014, a majority of the inmates reported that there was not a high enough presence of prison officers in the communal areas in sections B and C, and that this affected their sense of security. During the visit in 2018, the prison administration stated that internal guidelines for supervision in the communal sections were in place, but that the staffing situation had not improved. The prison had therefore changed the lock-up procedures, resulting in inmates being locked-up in their cells to a greater extent than in 2014. The Parliamentary Ombudsman is still concerned about the staffing situation in Bergen Prison's communal sections. The fact that the correctional service is unable to safeguard the inmates' security by means other than increasing the time inmates are locked up in their cells is a cause for concern.

Most of the inmates who had been in contact with the health service stated that they were followed up reasonably quickly, but that it could take a long time to get in touch with a doctor. The inmates' level of satisfaction with the follow-up from the health service varied, but most were satisfied.

Men and women serve together in Bergen Prison. Female inmates are a particularly vulnerable group in many respects. There were only male doctors in the prison, and there was no possibility for female inmates to be examined or treated by a female doctor.

# Recommendations

## Isolation and exclusion from company

### Physical conditions in the security cells

**Recommendations**

- The prison should immediately ensure that functional lights with dimmer switches are installed in all the security cells.
- A clock should be installed in the security cells.
- The prison should immediately ensure that a calling system is installed in the security cells, enabling the inmates to contact staff.

### Documentation and administrative decisions regarding the use of security cells

**Recommendation**

- The prison should immediately ensure that administrative decisions regarding the use of security cells are made in accordance with the requirements set out in current laws and guidelines.

### Supervision procedures and safeguarding of inmates

**Recommendation**

- The prison should ensure that the frequency of supervision fulfils the inmates' need for supervision, and that it is carried out in practice.

### Placements of minors in security cells

**Recommendations**

- Bergen Prison should ensure that juvenile inmates are never placed in security cells without continuous supervision and without this being documented at all times.
- Bergen Prison should ensure that juvenile inmates are never placed in security cells without staff being trained in the special rules that apply to minors.

### About the use of security cells in the event of an identified risk of suicide

**Recommendation**

- Bergen Prison should immediately implement measures to prevent the use of security cells for people who are deemed to be suicidal.

## Body searches and clothing during detainment in security cells

**Recommendations**

- Inmates should as a general rule be allowed to wear their own clothing during detainment in a security cell. In the event of an acute risk of suicide, where it is not deemed advisable for inmates to wear their own or the prison's clothing due to safety concerns, the inmates must be offered rip-resistant suicide prevention clothing.
- When conducting body searches, the prison officer should be the same sex as the inmate.

## Use of the restraint bed

**Recommendations**

- The prison should review its procedures and practice to discontinue the use of restraint beds.
- As a rule, restraint beds should never be used on minors. Bergen Prison should ensure that internal procedures are updated and that staff are trained in the special rules that apply should it be absolutely necessary to use restraint beds on juvenile inmates.

## Exclusion from company

**Recommendations**

- Bergen Prison should review reasons for exclusion pursuant to Section 37 of the Execution of Sentences Act and consider taking measures to reduce the number of administrative decisions and how long they apply.
- The prison should ensure that all inmates in section A-vest and A-øst have access to satisfactory and meaningful measures to compensate for the detrimental effects of isolation.
- The prison should ensure that it registers the number of inmates who are serving under conditions similar to isolation to ensure that its scope is clear to central government authorities.
- The prison should strengthen measures that can counteract the detrimental effects of isolation. Measures should also be established to ensure that inmates are released from isolation as quickly as possible.

## Health service

### Admission interview

**Recommendations**

- Health service staff should familiarise themselves with the Istanbul Protocol, and acquire expertise in uncovering abuse in accordance with the Protocol.
- The health service should have a camera available so that any injuries that the inmates may have can be documented by medical personnel in the patient records.
- The health service should ensure that suicide risk is always assessed in the initial admission interview.

### Women's health

**Recommendation**

- Steps should be taken to ensure that women who, for one reason or another, want a female GP have access to one.

### Medication

#### Recommendations

- The prison should ensure that all prison officers who hand out medication have completed a medication course.
- In connection with the distribution of medication, the prison and the health service, in collaboration with a pharmacy supervisor, should ensure that medical information is not disclosed in a manner that is in breach of the duty of confidentiality for medical personnel.

## The health service's role in connection with exclusions from company (isolation)

#### Recommendation

- The health service and the prison should develop procedures that state that a doctor shall be contacted without undue delay in connection with administrative decisions on isolation.

#### Recommendation

- The prison should ensure that confidentiality is maintained regarding all consultations with the healthcare department's medical staff, including with the dentist, physiotherapist, psychologist and psychiatrist. The prison should ensure that request forms for medical consultations are always put in a sealed envelope.

# 4 How the visit was conducted

In January 2018, Bergen Prison was notified that the Parliamentary Ombudsman's National Preventive Mechanism would carry out a visit in the course of 2018. The exact date of the visit was not announced. A separate notification was sent to the prison health service.

The visit was part of the follow-up of the Parliamentary Ombudsman's report published on 18 December 2014 containing findings and recommendations from the visit to Bergen Prison on 4–6 November 2014. In contrast to the visit in 2014, the Ombudsman's visit in May 2018 focused more on specific topics. The main purpose of the visit was to investigate the prison's practices in connection with exclusion from company and time spent outside the cells.

The visit took place in the period 2–4 May 2018. The Parliamentary Ombudsman's National Preventive Mechanism prioritised visiting the following sections: A-vest, A-øst and the women's section in section C. Some interviews were also conducted with male inmates in sections B and C.

The NPM interviewed a total of 33 inmates. The interviews were mainly conducted in the inmates' cells or in an interview room. No staff were present during any of the interviews. The interviews took place in either Norwegian or English.

During the visit, interviews were also conducted with prison officers, trade union representatives, and the health service.

On 24 May 2018, a concluding meeting was held with the prison administration via Skype, at which the preliminary findings were presented.

The visit was well organised by the prison.

The following persons participated from the Parliamentary Ombudsman:

- Aage Thor Falkanger, Parliamentary Ombudsman
- Helga Fastrup Ervik, Head of the NPM, Legal Adviser
- Christian Ranheim, Senior Adviser, Legal Adviser
- Johannes Flisnes Nilsen, Senior Adviser, Legal Adviser
- Anette Hansen, Senior Communications Adviser
- Aina Holmén, Senior Adviser, Psychologist
- Joar Øveraas Halvorsen, external expert, Psychologist

# 5 About Bergen Prison

Bergen Prison is Norway's second largest prison and has an ordinary capacity of 281 places, divided between 218 high security places and 63 lower security places. The NPM's visit did not include the prison's lower security section.

At the time of the visit, there were 190 inmates in the high security sections. Of these, 174 were men and 16 were women. The number of convicted inmates was 111, and the number of inmates remanded in custody was 78.

Bergen Prison comprises the following sections: A (A-vest and A-øst), B, C, and M high security sections. These are located inside the encircling wall. Visits were made to four sections:

**Section A-vest** comprised 24 cells in addition to three security cells and five holding cells.

The section had a separate exercise room where the inmates could exercise individually or in groups. Female inmates were occasionally placed in Section A-vest. These women were subject to court-ordered isolation, women transferred from other sections due to an administrative decision on exclusion from company, or women who were waiting for an available place in the women's section C. During the visit, four women had been placed in this section.

**Section A-øst** was established in 1999 to meet the need for more remand places. The section was mostly used as the admission section for male remand inmates who came from police custody facilities or other prisons. In the same way as section A-vest, this section also received inmates who, for various reasons, could not or did not want to be placed in the communal section. The section consisted of 53 cells, one of which was intended specifically for inmates with mobility impairments. A-øst was located close to the healthcare department in order to ensure that new inmates were followed-up.

**Section B** comprised 48 places for men divided into eight living units. In each living unit, there was a communal room with a kitchen. Most of the section's inmates had been transferred from section A-øst or A-vest. The substance abuse rehabilitation unit was located in section B.

**Section C** comprised 48 places divided between seven living units. Two of the living units were reserved for women. Each living unit comprised seven places divided between six cells, a communal room with a kitchenette, dining area and sofas.

# 6 Isolation and exclusion from company

## 6.1 Harmful effects of isolation

Extensive knowledge exists on isolation and the risk of suicide, self-harm and the development of serious mental disorders. Isolation can have a serious impact on the inmate's mental health and may incite more aggressive behaviour and weaken their impulse control.[3] It also increases the risk of suicide among inmates who are or have been in isolation.[4]

Research shows that even the short-term use of isolation can inflict psychological harm on inmates[5]. For remand inmates, research shows that the psychological effects of isolation arise quickly, and that the risk increases with each passing day.[6] For inmates who are in full isolation over time, the risk of permanent harmful effects of isolation increases, thereby also increasing the requirement of the scope and content of measures that must be implemented to counteract such effects. [7]

## 6.2 Human rights standards about the use of isolation

The Execution of Sentences Act provides a legal basis for excluding inmates from the company of other inmates and to place them in security cells. Both interventions may entail isolation, depending on their duration and regime.

International guidelines set out important requirements for what type of exclusion is deemed to constitute isolation, also referred to as solitary confinement. The UN Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) define solitary confinement thus:

> solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact.[8]

Pursuant to the Mandela Rules, solitary confinement shall only be imposed in exceptional cases as a last resort, for as short a time as possible and with an independent right to file a complaint, and only

[3]For a summary of research findings, see Sharon Shalev (2008) *A Sourcebook on Solitary Confinement,* LSE/Mannheim Centre for Criminology, pp. 15–17.

[4] Andersen et al., *A Longitudinal Study of Prisoners on Remand: Repeated Measures of Psychopathology in the Initial Phase of Solitary versus Nonsolitary Confinement*, 2000; Grassian, *Psychiatric Effects of Solitary Confinement,* 2006; Kaba et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 2014; Daniel & Fleming, *Suicides in a State Correctional System*, 2006; Duthé, Hazard, Kensey, and Shon, *Suicide among male prisoners in France: a prospective population-based study,* 2013; Felthous, *Suicide Behind Bars: Trends, Inconsistencies, and Practical Implications*, 2011; Konrad et al., *Preventing suicide in prisons Part I: Recommendations from the International Association for Suicide Prevention Task Force on Suicide in Prisons*. 2007; Patterson & Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation*, 1999 to 2004, 2008.

[5] See Smith, Peter Scharff, The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature. Crime and Justice, vol. 34, no. 1, 2006, side 495.

[6] See Horn, Thomas, *Fullstendig isolasjon ved bevisforspillelse* ('Full isolation in connection with risk of interference with evidence'). University of Oslo, the Faculty of Law, 2015 page 23.

[7] Shalev, Sharon, A Sourcebook on Solitary Confinement. Mannheim Centre for Criminology, London School of Economics and Political Science (2008) page 43.

[8] United Nations Standard Minimum Rules for the Treatment of Prisoners A/RES/70/175, Rule 44.

with the approval of a competent authority.[9] According to the rules, such solitary confinement must not be used for more than 15 days.[10]

However, Norwegian legislation currently allows complete exclusion from the company of others for up to one year at a time.

In its report on solitary confinement, the United Nations Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment concluded that solitary confinement can in some cases constitute a breach of international conventions.[11] The Special Rapporteur stressed the well-documented harmful effects that solitary confinement can have on the health of individuals.[12]

The European Committee for the Prevention of Torture (CPT) has also highlighted the risk of harmful health effects:

> [solitary confinement] can have an extremely damaging effect on the mental, somatic and social health of those concerned. This damaging effect can be immediate and increases the longer the measures lasts and the more indeterminate it is.[13]

Based on what is known about the harmful effects, the CPT has recommended that 'solitary confinement should only be imposed in exceptional circumstances, as a last resort and for the shortest possible time'. [14]

## 6.3 Use of security cells

Pursuant to Section 38 of the Execution of Sentences Act, the correctional service may make use of coercive measures in order to:

a) prevent a serious attack on or injury to a person,
b) prevent the execution of serious threats or considerable damage to property,
c) prevent serious riots or disturbances,
d) prevent escape from prison during transportation to or from a destination,
e) prevent unlawful intrusion into a prison,
f) secure access to a closed or barricaded room.

Pursuant to the Directorate of Norwegian Correctional Service's guidelines, security cells can only be used in the scenarios described by point a), b) or d).[15] The use of coercive measures must only take

[9] The Mandela Rules, Rule 45 No 1.
[10] The Mandela Rules, Rule 44
[11] The UN Special Rapporteur on Torture, Interim Report A/66/268 of 5 August 2011, page 19.
[12] The UN Special Rapporteur on Torture, Interim Report A/66/268 of 5 August 2011, paragraphs 54 and 55. See also the Istanbul Statement on the Use and Effects of Solitary Confinement: 'The central harmful feature of solitary confinement is that it reduces meaningful social contact to a level of social and psychological stimulus that many will experience as insufficient to sustain health and well-being.'
[13] CPT/Inf(2011)28-part2, paragraph 53.
[14] The CPT Standards, page 37, paragraph 64.
[15] The Directorate of Norwegian Correctional Service's guidelines to the Execution of Sentences Act, paragraph 38.4.

place when strictly necessary under the circumstances, and where less intrusive measures have been tried to no avail or would obviously be inadequate.[16]

Being placed in a security cell is a particularly invasive form of isolation. What is generally known about isolation and the risk of suicide, self-harm and the development of serious mental disorders, indicates that a security cell should only be used as a last resort and for the shortest possible time.

### 6.3.1 Physical conditions in security cells

The security cells were located next to section A-vest. There were three cells of 6, 8 and 13 square metres respectively. A restraint bed with belts of a modern standard was located in the largest cell. The other two cells were equipped with a plastic mattress and squat toilet in the floor. The visit team was informed that in cases where there was a risk of self-harm or suicide, a rip-resistant blanket and poncho were handed out.

The cells had windows that provided a limited view, a narrow opening in the door that facilitated supervision by staff, and a window over the door with a fluorescent light, which was meant to ensure lighting in the cell. This light was on as long as the inmate was in the cell, night and day, and the brightness could not be adjusted. A constantly, fully lit security cell constitutes an obvious risk of inhuman treatment and could cause great distress to the inmate. The Mandela Rules state the following:

> In no circumstances may restrictions or disciplinary sanctions amount to torture or other cruel, inhuman or degrading treatment or punishment. The following practices, in particular, shall be prohibited:
> […]
> (c) Placement of a prisoner in a dark or constantly lit cell;[17]

The floor and the walls were in contrasting colours, but there was no clock in sight for the inmates. Contrasting colours on the walls and access to a clock can prevent inmates from becoming disoriented during isolation.

The prison's security cells bore signs of wear and tear, and the size of the smallest cell bordered on the European Committee for the Prevention of Torture's (CPT) minimum recommendations.[18]

Each cell was equipped with a calling system, enabling inmates to contact staff. However, these did not work. According to the prison administration, the system had been disconnected to prevent too many unnecessary calls being made. The fact that inmates in security cells do not have access to the calling system to request assistance from the prison officers is very serious, and can obviously create anxiety among inmates. The prison administration stated that supervision was carried out every 30 minutes, and that this measure was intended to make up for the lack of a calling system. However, a review of the records from the security cells showed that this was not always the case in practice (see chapter 6.3.4 *Supervision and safeguarding*).

[16] The Directorate of Norwegian Correctional Service's guidelines to the Execution of Sentences Act, paragraph 38.2.
[17] The Mandela Rules, Rule 43
[18] The European Committee for the Prevention of Torture (CPT) requires a cell size of at least six square metres. This standard applies to both ordinary cells and security cells. CPT/Inf (2015) 44.

The cells had underfloor heating with a thermostat, and the prison administration said that the heating was turned up if temperatures dropped. However, record entries showed that some inmates complained that the security cells were cold.

Food was routinely passed to inmates through a hatch at floor level.

**Recommendations**

- The prison should immediately ensure that functional lights with dimmer switches are installed in all the security cells.
- A clock should be installed in the security cells.
- The prison should immediately ensure that a calling system is installed in the security cells, enabling the inmates to contact staff.

### 6.3.2 Scope and duration

In 2016, a total of 32 administrative decisions were made on the use of security cells pursuant to the Execution of Sentences Act Section 38. In 2017, 63 administrative decisions were made, and nine administrative decisions were made in the period January to May 2018. The large increase from 2016 to 2017 was mainly due to certain individual inmates being placed in security cells a number of times. Fifty-eight per cent of those detained in 2017 spent less than a day in a security cell, while 8 per cent spent more than two days in a security cell. In one instance, an inmate spent more than three days in a security cell

### 6.3.3 Documentation and administrative decisions regarding the use of security cells

Bergen Prison had a defined procedure for case processing in the event of confinement to a security cell. This set out important requirements for what should be noted in incident reports, administrative decisions and records.

Administrative decisions concerning the use of security cells were in general of a satisfactory quality. The actual circumstances on which the administrative decision was based were described, and the pertaining report also described, in most cases, any less invasive measures that had been attempted or assessed as obviously inadequate.

It is a cause for concern, however, that a number of the decisions regarding confinement to security cells were made pursuant to the Execution of Sentences Act Section 38 letter c) on the grounds that the inmate had been noisy and had thus created fear among the other inmates in the section. Pursuant to the Directorate of Norwegian Correctional Service's guidelines to the Execution of Sentences Act, section 38.4, security cells should only be used when strictly necessary under the circumstances set out in letters a), b) or d). The same requirement is included in the prison records to the Execution of Sentences Act Section 38. It is, therefore, a cause of concern that 12 administrative decisions were made in 2017 pursuant to alternative c), and, are thus, at odds with the Directorate of Norwegian Correctional Service's guidelines. A number of administrative decisions were also made, based on instances where inmates had been noisy or had kicked the cell door, pursuant to the Execution of Sentences Act Section 38 letter b) to 'prevent the implementation of serious threats or considerable damage to property'. These incidents are not covered by this legal provision.

**Recommendation**

- The prison should immediately ensure that an administrative decision regarding the use of security cells is made in accordance with current laws and guidelines.

### 6.3.4 Supervision procedures and safeguarding of inmates

Being placed in a security cell is a particularly invasive form of isolation. What is generally known about isolation and the risk of suicide, self-harm and the development of serious mental disorders, indicates that good procedures should be in place for supervising and safeguarding people placed in security cells.

The Directorate of Norwegian Correctional Service's guidelines to the Execution of Sentences Act state the following:

> Security cells and restraint beds must not be used longer than absolute necessary, and the restrained inmate shall receive the necessary attention and care. The staff shall check on the inmate at least once per hour, and continuous monitoring should be considered. The inmate shall also be seen by health personnel at least once a day. The prison governor shall enquire about the inmate's condition on a daily basis, and whether the use of coercive measures can be discontinued must be continuously assessed.[19]

The security cells in Bergen Prison were organised under section A-vest, and the staff in this section was responsible for carrying out supervision. The information to be registered in the supervision records was specified in the prison's procedures. This included the inmate's condition, and conversations with staff and the health service. A review of the records also showed that lengthy conversations had been documented with staff and the health service.

A review of the records related to the use of security cells in 2017 showed that supervision was normally carried out once every hour, but that the frequency had increased to twice every hour in 2018. In a number of instances where an acute risk of suicide or self-harm had been identified, more frequent supervision was required. The records showed, however, that the degree to which the supervision frequency was upheld varied considerably in practice. The issue was exacerbated by the fact that the calling system was disconnected.

The use of a security cell was discontinued after a conversation with the principal prison officer, and the many short periods spent in security cells show that such conversations took place relatively quickly. The prison stated that discontinuation was, nonetheless, never considered during a night shift, and that inmates who had not been transferred to a security cell during the day or evening shift, had to wait until the next day to be assessed.

The health service was routinely informed about placements in security cells. The records revealed that the inmates were not supervised by medical personnel outside office hours, which were from 7.15–21.45 on weekdays and 9.00–16.15 on Saturdays and public holidays.

[19] The Directorate of Norwegian Correctional Service's guidelines to the Execution of Sentences Act, paragraph 38.4.

**Recommendation**

- The prison should ensure that the frequency of supervision fulfils the inmate's need for supervision, and that it is carried out in practice.

### 6.3.5 Placements of minors in security cells

Bergen Prison made six administrative decisions concerning the use of security cells in the case of two juvenile inmates in the course of 2017. The longest placement lasted 15 hours. Both were transferred from the Juvenile Unit in Bjørgvin Prison, which until 28 November 2017 did not have its own approved security cell.

The use of security cells for juvenile offenders is a highly invasive measure that is potentially very harmful. In a report about detained children, the former UN Special Rapporteur on Torture, Juan E Méndez, expressed the following:

> Children experience pain and suffering differently to adults owing to their physical and emotional development and their specific needs. In children, ill-treatment may cause even greater or irreversible damage than for adults. Moreover, healthy development can be derailed by excessive or prolonged activation of stress response systems in the body, with damaging long-term effects on learning, behavior and health.[20]

He continues:

> In accordance with views of the Committee against Torture, the Subcommittee on Prevention of Torture and the Committee on the Rights of the Child, the Special Rapporteur is of the view that the imposition of solitary confinement, of any duration, on children constitutes cruel, inhuman or degrading treatment or punishment or even torture.[21]

In the Norwegian Official Report NOU 2008:15, reference is made to the fact that the detrimental effects of isolation on children can be both acute and chronic:

> «Slike skadefølger kan blant annet være søvnvansker, konsentrasjonsproblemer, forstyrret tidsopplevelse og døgnrytme, angstanfall, tretthet, apati, hallusinasjoner og forfølgelsesforestillinger. Barn som har begått straffbare handlinger er i utgangspunktet en belastet og sårbar gruppe som vil være spesielt sårbar for skadefølger.»[22] [Such detrimental effects may include difficulty sleeping, lack of concentration, confused sense of time and circadian rhythm, anxiety attacks, fatigue, apathy, hallucinations, and paranoia. Children who have committed criminal acts are a marginalised and vulnerable group who will be particularly vulnerable to detrimental effects.] (In Norwegian only.)

[20] The UN Special Rapporteur on Torture, A/HRC/28/68 paragraph 33, 5 March 2015
[21] The UN Special Rapporteur on Torture, A/HRC/28/68 paragraph 44, 5. March 2015
[22] NOU 2008: 15 Barn og straff – utviklingsstøtte og kontroll [Children and punishment – development support and control]

The Execution of Sentences Act Section 38 states that security cells should only be used if absolutely necessary, for the shortest time possible, with constant supervision and continuous evaluations of whether there are grounds for upholding the measure.

In the report written after the visit to the Juvenile Unit in Bjørgvin Prison in 2015, the Parliamentary Ombudsman emphasised that when security cells were used for minors, it was important that they were constantly supervised and that continuous assessments were logged clearly in the supervision records.[23]

The Juvenile Unit in Bjørgvin Prison informed the Parliamentary Ombudsman that the adolescents who were placed in Bergen Prison were accompanied by a member of staff from the Juvenile Unit, but that Bergen Prison was responsible for both making an administrative decision to place them in security cells and for supervision and record keeping.

A review of the administrative decisions and the records raises grave concerns, in particular considering the inmates' young age.

- The records showed that they were not constantly supervised during the first nine hours of their initial confinement to a security cell, despite this being a statutory requirement.
- The records revealed that a male prison officer had been present during at least one body search in connection with the placement of a female inmate in a security cell. The Parliamentary Ombudsman was informed that the body search was carried out against the girl's will.
- One of the stays had not been entered in the records. This meant it was not possible to follow up how the inmate had been treated during the 13 hours spent in the security cell.
- In these six instances, the quality of the record keeping varied.

The Parliamentary Ombudsman was informed that following the approval of the Juvenile Unit's own security cell, no inmates had been transferred to the security cell in Bergen Prison.

**Recommendations**

- Bergen Prison should ensure that juvenile inmates are never placed in security cells without continuous supervision and documentation of this.
- Bergen Prison should ensure that juvenile inmates are never placed in security cells without staff trained in the particular regulations that apply for minors.

### 6.3.6 In particular about the use of security cells in the event of identified risk of suicide

A review of records from 2017 showed that security cells were used in a total of 15 instances to prevent suicide or self-harm. This amounts to 24 per cent of all detentions in security cells. Four of nine placements in security cells between January and May 2018 were imposed to prevent suicide or self-harm.

[23] The Parliamentary Ombudsman's report to the Juvenile Unit in Bjørgvin Fengsel, 22 February 2015, pp. 24-25.

Documentation obtained from the prison showed that four suicide attempts were registered in 2017. After these suicide attempts, all four of the inmates were placed in a security cell. The supervision records showed that the medical personnel, with one exception, had carried out conversations with the inmates relatively quickly after their placement in a security cell. In one of the instances, the suicide attempt took place on a public holiday. The prison officers then had a lengthy conversation with the inmate immediately after being placed in a security cell, but a visit from the health service was not logged until almost 16 hours after the suicide attempt.

The prison administration stated that a shortage of resources, which meant it was not possible to provide supervision during the evening and night shifts in the ordinary sections, was a contributing factor to placement in holding cells or security cells. A review of the records showed that several placements took place in this period, but several inmates were also placed in security cells during the day. Research conducted by the Correctional Service has found that conversations with inmates are probably the most effective preventive measure against suicide.[24] No information emerged from the administrative decisions or the records that this had actually taken place *before* placement in a security cell.

The Execution of Sentences Act Section 38 sets out strict requirements for necessity and proportionality in the use of coercive measures. The correctional service should only use coercive measures when strictly necessary under the circumstances, and only after attempting to use less coercive measures that have proved inadequate. It is a serious and reprehensible matter that persons in an acute life crisis are placed in a security cell and that the resource situation is partly to blame for this.

The limited resources available to Bergen Prison has increased the risk of focusing on static safety alone through reducing the risk of physical harm. This should not be at the expense of efforts to create a sense of safety for those who are suicidal. Suicidal people need attention, help and support, and they need to be in contact with empathic, listening and non-judgemental people who show understanding and are able to create a good relationship.[25] This means that the staff who supervise suicidal inmates must have the appropriate personal qualities and time. Competent staff must have the time and opportunity to be in close contact with suicidal inmates.

**Recommendation**

- Bergen Prison should immediately implement measures to prevent the use of security cells for people who are deemed to be suicidal.

24 Hammerlin, Yngve, Selvmord og selvmordsnærhet i norske fengsler – Selvmordsforebyggende arbeid i fengsel ('Suicide and suicidality in Norwegian prisons – Suicide prevention work in prison' ), 2009, p. 109, the Correctional Service of Norway Staff Academy (KRUS).

[25] Hagen, J., Hjelmeland, H., Espeland, K., Knizek, B. L. (2018). Bedre omsorg, færre selvmord? *Tidsskriftet Den norske Legeforening*, and Marzano, K. Hawton, Rivlin, A. et al. (2016). Prevention of suicidal behaviour in prisons, *Crisis, pp. 330-331.*

### 6.3.7 Body searches and clothing in security cells

Several prison visits have resulted in the Parliamentary Ombudsman criticising the practice of routine body searches involving full removal of clothing when inmates are placed in security cells.[26] The CPT criticised a similar practice involving the use of security cells after a visit to Denmark in February 2014:

> In the CPT's view, only where there is an evident suicide risk or case of self-harm should an inmate have to remove his or her clothes and, in such cases, the inmate should be provided with rip-proof clothing and footwear. The prisoner's clothing should not be removed unless this is found to be justified following an individual risk assessment.[27]

During the last visit to Bergen Prison in 2014, the Parliamentary Ombudsman found that the inmates were routinely body-searched, and that they were given underwear and a woollen blanket to cover themselves. Women were also given a t-shirt. Replying to the report, the prison wrote the following:

> «Rutinebeskrivelse for innsettelse er blitt revidert hvor det fremgår at det skal foretas en konkret vurdering av nødvendigheten av kroppsvisitasjon i form av full avkledning. Videre har vi til hensikt å anskaffe rivesikre klær til bruk på sikkerhetscelle.»[28] [The routine procedure for placement has been revised which states that a concrete assessment of the necessity for body searches involving full removal of clothing will be carried out. Furthermore, we intend to acquire rip-resistant clothing to be used in security cells.] (In Norwegian only.)

In November 2017, the Directorate of Norwegian Correctional Service distributed a proposal for consultation to change the guidelines regarding the use of coercive measures. Section 38.7.1 of the draft specifies that inmates placed in security cells or restraint beds must always be searched. This is not in accordance with the CPT's recommendations, which state that individual risk assessments should always be carried out. Neither have the proposed changes to the new guidelines entered into force. In spite of this, Bergen Prison has changed its internal procedures to ensure that all inmates who are to be placed in a security cell or restraint bed are body searched. The prison confirmed that inmates were routinely fully undressed, and dressed in the prison's own clothing consisting of underwear, sweatpants and a t-shirt. It has also purchased rip-resistant blankets and ponchos to be used in the case of a risk of suicide.

While the guidelines pursuant to the Execution of Sentences Act state that body searches, as far as practically possible, should be carried out by staff of the same sex as the inmate, international guidelines clearly state that body searches must be carried out by people of the same sex.[29] Documentation showed that body searches of female inmates in security cells had been carried out with male prison officers present. No information was provided about the role of the male prison

[26] The Parliamentary Ombudsman's report from the visit to Tromsø Prison on 10–12 September, page 9, paragraph 5.1.3, and the report from the visit to Bergen Prison on 4–6 November 2014, page 10, paragraph 5.1.1.
[27] CPT's report after a visit to Denmark on 4–13 February 2014, CPTInf/ (2014) 25, page 40–42, paragraphs 64–66.
[28] Bergen Prison's follow-up of the Parliamentary Ombudsman's report after the visit to Bergen Prison on 4–6 November 2014, letter dated 16 March 2015, page 2. Available in Norwegian on the Parliamentary Ombudsman's website.
[29] The Mandela Rules, Rule 52.1, and the European Prison Rules, Rule 54.5 and the Bangkok Rules, Rule 19.

officer during the body search. When male inmates had been body searched, information also emerged that indicated that female members of staff had been present.

Although there may be safety or resource-related grounds for such decisions, it is underlined that situations such as this can be traumatic and entail a risk of inhuman treatment.

**Recommendations**

- Inmates should as a general rule be allowed to wear their own clothing during detainment in a security cell. In the event of an acute risk of suicide, where it is not deemed advisable for inmates to wear their own or the prison's clothing due to safety concerns, the inmates must be offered rip-resistant suicide prevention clothing.
- When conducting body searches, the prison officer should be of the same sex as the inmate.

## 6.4 Use of restraint beds

The use of restraint beds is a very invasive coercive measure. Restraint beds must only be used, therefore, to prevent inmates from harming themselves.[30]

Bergen Prison had one restraint bed placed in one of the three security cells. The bed was an old model, while the belts were of a modern standard.

The bed had been used once in the course of 2016 and once in 2017. The incident in 2016 concerned a minor who was restrained after a suicide attempt in the security cell one Sunday evening. The inmate remained strapped to the restraint bed for more than 13 hours without medical supervision and, at times, sleeping. The inmate was then brought back to the security cell and made to wear a rip-resistant poncho. No information is provided in the documentation received by the Parliamentary Ombudsman about how the inmate managed to attempt suicide in the security cell.

Pursuant to the Execution of Sentences Act Section 38 third paragraph, coercive measures can only be used on minors if absolutely necessary. The threshold for use of security cells and restraint beds is hence significantly higher than for adult inmates. The need to uphold such a measure should also be continually assessed. In light of the information received by the Parliamentary Ombudsman, it is of grave concern that a restrain bed was used on the minor, and that the measure was maintained over a relatively long period of time. A review of the prison's procedures on the use of restraint beds showed that these did not include separate points for the use of restraint beds in cases involving juvenile inmates.

According to the records, the grounds for the incident in 2017 was self-harm, and the inmate was placed in a restraint bed for three hours and forty minutes. The records showed that the inmate was calm, and that he ate and slept during the period he was restrained. He had also used the toilet facilities in another cell, before again being restrained. It is not clear why an inmate who had calmed down enough for the belts to be removed, had to return to the restraint bed after going to the toilet. According to the prison's own guidelines, an assessment about whether an administrative decision

[30] The Directorate of Norwegian Correctional Service's guidelines to the Execution of Sentences Act, paragraph 38.4.

should be upheld or not must be logged. No such assessment had been logged until three hours had passed, in spite of the inmate appearing calm. The use of restraint beds is a very invasive measure, and the lack of a continuous assessment of whether the conditions for its use are actually met is a cause for concern.

**Recommendations**

- The prison should review its routines and practice to discontinue the use of restraint beds.
- As a rule, restraint beds should never be used on minors. Bergen Prison should ensure that internal routines are updated and that staff are trained in the particular rules that apply should it be absolutely necessary to use restraint beds on juvenile inmates.

## 6.5 Exclusion from company

### 6.5.1 Legal basis

The main rule is that inmates, as far as practically possible, should have access to the company of others during work, training, programmes, or other measures, and during their free time. Pursuant to Section 37 of the Execution of Sentences Act, the prison may decide that an inmate should be completely or partly excluded from the company of others if this is necessary in order to prevent the inmate from continuing to influence the prison environment in a particularly negative manner, to prevent prisoners from injuring themselves or acting violently or threatening others, to prevent considerable material damage, to prevent criminal acts, or to maintain peace, order and security, or if the prisoner himself or herself so wishes. The prison can also exclude inmates from the company of others if matters relating to the building or staff make this necessary.

A decision to exclude an inmate always requires an administrative decision to be made. The exception is very short lock-ups of inmates, for instance up to an hour in connection with inmate counts, shift changeovers, meals, etc.

Complete or partial exclusion shall not be maintained longer than necessary, and the prison shall continually assess whether grounds for the exclusion continue to exist.

### 6.5.2 Exclusion from the company of others: Scope and duration

In 2016, Bergen Prison made 399 administrative decisions regarding complete exclusion from company, pursuant to the Execution of Sentences Act Section 37. During the same period of time, seven administrative decisions were made regarding partial exclusion from company.

In 2017, 446 administrative decisions were made regarding complete exclusion from company pursuant to the Execution of Sentences Act Section 37, and five administrative decisions were made regarding partial exclusion from company. Bergen Prison is one of the biggest prisons in Norway, and statistics from the Directorate of Norwegian Correctional Service show that Bergen Prison has the highest number of administrative decisions on exclusion from company measured by the number of administrative decisions pursuant to the Execution of Sentences Act Section 37. Measured by the number of hours inmates are excluded from company, only Åna Prison came higher than Bergen Prison. These numbers indicate that Bergen Prison does not make administrative decisions about exclusion in section A-øst, despite the inmates being detained for several days a week in conditions

corresponding to isolation (se chapter 6.5.6 *About exclusion from company with an administrative decision in section A-øst*).

Statistics from Bergen Prison show that almost 94 per cent of administrative decisions are in connection to exclusions from company to maintain peace, order, and safety. Compared to other prisons the Parliamentary Ombudsman has inspected, the number of exclusions based on the wishes of the inmates themselves has been low with only 9 administrative decisions in 2017.[31] During the visit, however, the Parliamentary Ombudsman spoke to several inmates who had been detained in section A-øst who claimed they were excluded at their own request, but where no such administrative decision of exclusion existed. It would appear that the number of reported administrative decisions was thus lower than the actual number of exclusions at own request.

At the time of the visit – in addition to exclusion pursuant to the Execution of Sentences Act Section 37 – four of the remanded inmates were subject to court-ordered isolation pursuant to the Act on the Execution of Sentences Section 186 a (full isolation due to risk of interference with evidence).

### 6.5.3 Exclusion and isolation in section A-vest

Section A-vest comprised 24 cells in total. The section had, in addition, responsibility for the three security cells and five holding cells. The ordinary cells located in section A-vest were approx. eight square metres and comprised a bed, chest of drawers, desk with a TV-screen, fridge and a two-way calling system. The rooms had a separate screened area with a toilet and shower. The lights could be dimmed from the cell.

The visit team was informed that all the inmates in section A-vest were there, either due to administrative decisions on exclusion from company, or due to court-ordered restrictions. At the time of the visit, there were four convicted inmates and 15 inmates remanded in custody in the section. Of the 19 inmates, 15 were men and four were women.

During the visit, members of staff and inmates stated that women were occasionally placed in section A-vest if there were no available places in the women's section in section C, and that women could not be placed in the intake department A-øst. It is a matter of grave concern that women are placed in a restricted section due to a lack of places and resources. This issue has been raised before by the Parliamentary Ombudsman, for instance in the thematic report, 'Women in prison'.[32]

The Regulations to the Execution of Sentences Act Section 3-35 second paragraph stipulate that detrimental effects of exclusion from company, as far as possible, must be prevented or remedied. The guidelines pursuant to the Execution of Sentences Act stipulate that staff must make efforts to alleviate the negative effects of exclusion.[33] The need for compensatory measures increases with the duration of the exclusion.

In our report after the visit to Bergen Prison in 2014, we noted that section A-vest was characterised by extensive use of isolation and a lack of activity. Many of the inmates expressed then that they felt

[31] In comparison, the two previous prisons visited by the Parliamentary Ombudsman, Åna (153 high-securityplaces) and Arendal (32 high-security places), had made 90 and 36 administrative decisions respectively in connection with exclusions at own request in 2017.
[32] Women in prison, a thematic report by the Parliamentary Ombudsman, 2017, p. 28.
[33] The Directorate of Norwegian Correctional Service's guidelines to the Execution of Sentences Act paragraph 37.20.

that the prison officers were busy, and that they received little follow-up and had little contact with them. The Parliamentary Ombudsman recommended that the prison implement measures to ensure that all inmates who were not subject to court-ordered restrictions (full isolation) had an opportunity to spend at least eight hours a day on meaningful activity outside their cells. Separate measures should be implemented for inmates subject to court-ordered full isolation.

Reference was also made to the report of the European Committee for the Prevention of Torture (CPT) after a visit to the prison in 2011:

> In contrast, prisoners held in Unit A-West at Bergen Prison and Unit A at Skien Prison were subjected to a relatively impoverished regime. Both units accommodated newly-admitted prisoners pending their transfer to an ordinary detention unit, as well as prisoners who, for various reasons, could not be held together with other prisoners (e.g. remand prisoners under court-ordered restrictions, prisoners with mental problems, prisoners segregated on a voluntary basis from the mainstream inmate population, etc. [...] The CPT recommends that out-of-cell activities for prisoners held in the above-mentioned units of Bergen and Skien Prisons be improved as a matter of priority.

In their reply, Bergen Prison stated that in order to be able to increase the level of activity in the section, it would also have to increase the number of staff dedicated to such work. In addition, they would have to evaluate whether it would be possible to find suitable premises for this. They also stated that inmates in isolation were a priority, but that they lacked the resources to be able to follow them up in the manner they wished.

During the visit in 2018, most of the people we spoke to said that they made use of the exercise room and the opportunity to spend an hour outside every day. Several also said that they had been taken on walks, either on the grounds or on the football field when the staff had time to do this. Several had access to a DVD player and books. Despite this, many still complained over too much isolation and too little activity. During this visit, reference was made to the fact that the prison's staff resources and time allocated to the individual inmate had consistently worsened compared with the Parliamentary Ombudsman's visit in 2014.

### 6.5.4 About the use of holding cells

During the visit in 2014, the Parliamentary Ombudsman stated that some of the holding cells had obvious similarities to the security cells, and concluded that the use of holding cells did not have a legal basis in the Execution of Sentences Act. The prison administration replied that they had started to make improvements to the holding cells in order to make them look more like ordinary cells, and thus be able to use them for exclusion from company pursuant to Section 37.

In 2018, the National Preventive Mechanism (NPM) inspected the modified holding cells. They had now been equipped with windows with air vents, a bed, bedside table and built-in TV. All the cells had a closed-off area with a toilet, a small washbasin and a shower. A two-way calling system had also been installed. The cells now looked more like ordinary cells than they did in 2014, despite the fact that they were still located in the security section.

### 6.5.5 Exclusion and isolation in section A-øst

Section A-øst was established in 1999 to meet the need for more remand places. However, the section also receives convicted inmates pending an available place in other sections, and inmates

who, for various reasons, cannot or do not want to be in the communal section. The are 53 cells in section A-øst. When the NPM visited, there were 49 male inmates in the section. Of these, 30 were remanded in custody and 19 were convicted inmates.

The report written after the NPM's visit in 2014 described the inmates' situation in section A-øst as demanding. Several inmates reported that detention was very hard with widespread use of isolation and little contact with both inmates and members of staff. The prison administration stated that A-øst was not a section built for social interaction, and that the intention was that inmates should be transferred to sections with less restrictions as quickly as possible. It was, therefore, a particular cause for concern that several inmates stated that they had spent long periods of time in the section.

During the visit in 2018, it was stated that some of the inmates in section A-øst went to school, and that the section had five places in the workshop.

In order to improve the activity programme in the section, an activity room was built in 2016. This room included sofa groups, a TV, a ping-pong table, fussball table, magazines, books, and various board games. Inmates also had the opportunity to borrow films. Due to the large number of inmates in the section, each inmate could spend a total of ten hours in the room divided into four sessions in the course of one week. On one of these days, the social interaction period in the activity room was limited to one hour. This meant that many of the inmates, excluding time in the exercise yard, in reality did not have access to social interaction three days a week, and were isolated in their cells for 22 hours or more four days a week. Several inmates complained about the poor exercise options in the section.

Although the inmates have a better activity programme than was the case during the 2014 visit, the section still makes extensive use of isolation. A number of inmates are still in the section for long periods of time. Most of the inmates who had stayed in A-øst over time, were excluded from company at their own request, and many expressed that the difficult prison conditions impacted them psychologically.

The Parliamentary Ombudsman makes reference to the European Committee for the Prevention of Torture's standards, which points out that inmates should spend at least eight hours outside their cells per day.[34] In spite of the section now having an activity room, which is an improvement since the last visit, section A-øst is still characterised by being a closed, restricted section with a high degree of lock-ups and isolation.

#### 6.5.6 About exclusion from company without an administrative decision in section A-øst

During the visit, it emerged that only one of the inmates in section A-øst had received an administrative decision on exclusion from company.[35] This was confirmed by the prison administration, who stated that this was a topic that had been discussed internally, with the region, and with the Directorate of Norwegian Correctional Service. Reference was made to the fact that administrative decisions were previously made based on matters relating to prison premises and staffing, but due to the high number of inmates in the section this involved extensive case processing which took a lot of time. Questions were also raised about which situations demanded an

[34] CPT standards, page 17, paragraph 47.

[35] Some of the inmates in the section were subject to court-ordered restrictions or sanctions pursuant to the Execution of Sentences Act Section 40.

administrative decision, and about the lines drawn between full exclusion, partial exclusion, and social interaction.

After the visit, the Parliamentary Ombudsman asked the Correctional Service Region West for a statement outlining the assessments made by the region regarding the need for administrative decisions in Section A-øst. The response came in the form of a letter dated 28 August 2018, which provided information about assessments and the correspondence with the Directorate of Norwegian Correctional Service.

A letter from the Correctional Service Region West to all the prison units in the region, dated 28 April 2016, specified that if the section lacked a certain amount of routine social interaction, the inmates should be considered excluded from company. The region further specified that some sections could have a limited degree of social interaction without the inmates being considered excluded from company. Social interaction should be defined as established, regular activities that are available to all inmates. The Parliamentary Ombudsman understands that these guidelines, combined with the completion the same year of the activity room that provides limited social interaction, have led to Bergen Prison no longer making administrative decisions on exclusion from company for most of the inmates in section A-øst.

The Parliamentary Ombudsman specifies that all inmates, as a general rule, should have access to social interaction both during activities and in their free time. This is pursuant to the Execution of Sentences Act Section 17 first paragraph:

> Insofar as this is practically possible, inmates shall be allowed company during work, training, programmes or other measures, and in leisure periods. The Norwegian Correctional Service may decide on complete or partial exclusion from company pursuant to the provisions of Section 29, paragraph two and Sections 37, 38, 39 and 40, paragraph two (d).

The preparatory works provide guidelines on what the limitation 'practically possible' entails, cf. the special comments to Section 17 in proposition to the Odelsting No 5 (2000— 2001):

> As far as practically possible, the inmates should have access to social interaction during work, training, when taking part in programmes or other measures, or in their free time. Limitations due to the premises, such as a lack of communal premises, maintenance work or necessary renovations, can make exclusion from company necessary during parts of the day. Limitations must otherwise be warranted by law (exclusion from company as a preventive measure pursuant to Section 37, use of coercive measures in prison pursuant to Section 38, immediate exclusion following violation of Section 39, and restricted social interaction as a reaction to violation of Section 40 second paragraph letter d).

The comments in the preparatory works indicate that the restriction referred to in the term 'practically possible', can justify exclusion from company 'parts of the day' and based on 'limitations due to the premises'.

The Directorate of Norwegian Correctional Service states in its guidelines to the Execution of Sentences Act that no quantitative definition of the terms 'exclusion' and 'company' can be derived

from the Execution of Sentences Act and the preparatory works.[36] The Correctional Service describes this further:

> Social interaction in a section will be defined by the prison section's ordinary schedule, which will be based on the concrete activity programme – how work, recreational activities, studies or participation in programmes are carried out, but also based on the prison's occupancy level, safety concerns, and the prison layout.[37]

It is unfortunate and obviously problematic that it is up to each prison to determine the amount of time allocated to daily social interaction in each section. The Parliamentary Ombudsman has pointed this out in, among other things, its consultation response to the proposed new guidelines for exclusion of company, pursuant to the Execution of Sentences Act Section 37.[38] During visits, the National Preventive Mechanism has observed that this has led to major differences in the time allocated to social interaction between different prison sections, and different practices for when administrative decisions are made in sections with limited social interaction.

In Section A-øst, contact with other inmates consisted of the opportunity to spend time in the activity room four times a week. These sessions lasted for 3 hours and 25 minutes twice a week, 2 hours and 10 minutes once a week, and 1 hour once a week, respectively. In addition, the inmates had the opportunity to spend one hour a day in the exercise yard. No communal activities were scheduled for the remaining three days, with the exception of the one hour spent outside. Seen in light of the preparatory works, the fact that administrative decisions are not made on exclusion of inmates who have no other option than to spend time in the exercise yard, appears to be in breach of the Execution of Sentences Act Section 17. These specify that limited social interaction can take place 'parts of the day', but not during the *whole* day, as is the situation in practice in section A-øst on four out of seven days.

It is deemed to be even more serious that this type of practice, which means that inmates are locked in their cells for a minimum of 22 hours for four out of seven days, counts as being placed in the communal section. This means that inmates placed in a communal section in Norway, are in fact placed in conditions corresponding to solitary confinement according to approved international standards. The Parliamentary Ombudsman cannot see that this is legally acceptable, and that this practice constitutes a clear risk of inhuman treatment. The Parliamentary Ombudsman spoke to inmates who had been in section A-øst for many weeks, some for months, and one inmate for more than one year.

An administrative decision also cannot be made to exclude inmates from company pursuant to Section 37 of the Act, which only allows exclusion from company due to acute circumstances relating to prison premises and staffing, and not due to ongoing resource challenges.

As a consequence of this, a large proportion of the isolated inmates in Bergen Prison are not included in the statistics on isolated inmates, and some inmates thus lose important legal safeguards. In addition, several of the inmates the NPM spoke to were isolated at their own request, and therefore

[36] Point 37.4 of the Guidelines to the Execution of Sentences Act.
[37] Ibid.
[38] Available at https://www.sivilombudsmannen.no/publikasjoner/horingsuttalelser/

chose not to spend time in the activity room or outside. Only in one instance, had an administrative decision been made on exclusion from company.

In its concluding report submitted in June 2018 regarding the situation in Norway, the UN Committee against Torture raised the matter of inmates serving under conditions similar to isolation. The Committee stated that it was concerned about the situation in Norway, where inmates were detained in conditions similar to isolation without any legal basis for the administrative decisions made.[39]

The Parliamentary Ombudsman agrees with the concerns expressed by the Committee, and has visited several prisons where the situation has been similar to that in Section A-øst. The findings show that the central government authorities urgently need to introduce guidelines that ensure social interaction between inmates in accordance with our international commitments in all situations where there is no legal basis for exclusion from company. The Parliamentary Ombudsman makes reference to Rule 37 in the Mandela Rules, where it is stated that the use of solitary confinement must always be warranted by laws and regulations.

The Parliamentary Ombudsman will follow this up in dialogue with the Directorate of the Norwegian Correctional Service and the Ministry of Justice and Public Security.

## 6.6 About isolation of persons with mental health problems

A high risk of harm to health is associated with isolation, particularly to mental health. Persons with mental health problems are therefore particularly vulnerable to isolation. A number of international guidelines and conventions therefore deal explicitly with the isolation of mentally ill inmates in prison. The Mandela Rules state that:

> The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures.[40]

Article 15 of the Convention on the Rights of Persons with Disabilities (CRPD) requires states to ensure that persons with intellectual disabilities are not subjected to torture or cruel, inhuman or degrading treatment or punishment. The CRPD Committee has underlined that mentally ill persons shall not be isolated if this can lead to their condition deteriorating, and that such placement may be in violation of Article 15:27 of the CRPD.

The European Court of Human Rights has considered the issue of imprisonment of persons with mental health problems in several judgments, and it has found states guilty of violations of the European Convention on Human Rights Article 3 in a number of cases where mentally ill persons have not received adequate treatment in prison.[41]

The UN Special Rapporteur has stated that:

[39] UN Committee against Torture, Concluding observations on the eighth periodic report of Norway, 5 June 2018, CAT/C/NOR/CO/8

[40] The Mandela Rules, Rule 45

[41] For an overview of case law, see the ECtHR's fact sheet on detention and mental health: http://www.echr.coe.int/Documents/FS_Detention_mental_health_ENG.pdf

> States should abolish the use of solitary confinement for juveniles and persons with mental disabilities. In regard to the use of solitary confinement for persons with mental disabilities, the Special Rapporteur emphasizes that physical segregation of such persons may be necessary in some cases for their own safety, but solitary confinement should be strictly prohibited.

In its standards, the CPT has stated that:

> A mentally ill prisoner should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff. That facility could be a civil mental hospital or a specially equipped psychiatric facility within the prison system. Whichever course is chosen, the accommodation capacity of the psychiatric facility in question should be adequate; too often there is a prolonged waiting period before a necessary transfer is effected. The transfer of the person concerned to a psychiatric facility should be treated as a matter of the highest priority.[42]

It emerged during the visit – among other things, from conversations with staff – that there were regularly inmates at Bergen Prison with such severe mental disorders and low level of functioning that they were generally unable to be part of the ordinary prison community. These inmates risked being excluded from section A-vest for long periods of time. In addition, there were several inmates who, due to mental disorders among other things, chose to isolate themselves in section A-øst.

In instances where the inmates had symptoms of serious mental illness, the health service stated that it considered emergency hospitalisation. Transferral to observation or treatment in the specialist health service could, nonetheless, prove very challenging, and if inmates refused to be hospitalised, they often ended up in isolation in prison without medical treatment.

The Parliamentary Ombudsman takes a very serious view of the situation in which individuals with mental health problems are subject to long-term isolation. The Norwegian authorities have a duty to ensure that inmates with mental illness who are detained in prisons are not subjected to undignified, degrading or inhuman treatment.

**Recommendations**

- Bergen Prison should review reasons for isolation pursuant to Section 37 of the Execution of Sentences Act and consider taking measures to reduce the number of administrative decisions and how long they should apply.
- The prison should ensure that all inmates in section A-vest and A-øst have access to satisfactory and meaningful measures to compensate for the detrimental effects of isolation.
- The prison should ensure that it registers the number of inmates who are serving under conditions similar to isolation to ensure that its scope is clear to central government authorities.
- The prison should strengthen measures that can counteract the detrimental effects of isolation. Measures should also be established to ensure that inmates are released from isolation as quickly as possible.

[42] 3rd General Report of the CPT, published in 1993, CPT/Inf(93)12-part, paragraph 43.

# 7 Safety and procedures for letting inmates out of their cells in sections B and C

During the visit in 2014, a majority of the inmates reported that there was not a high enough presence of prison officers in the communal areas in sections B and C. The prison administration described a complicated staffing situation. Reference was made to the fact that the prison was built with small living units, which, in principle, are well suited for prison officer involvement. Previously, each living unit had been staffed with at least one prison officer who was to be present together with the inmates. The prison administration stated that the resource situation meant that this staffing model was no longer possible. This meant that each prison officer was responsible for following-up several living-units during the course of a shift. The duty rooms, which served as the prison officers' base during shifts, were located far away from the living units with a number of closed doors between them. In addition, the windows in the duty rooms prevented anyone from looking out of or into the rooms. This contributed to a sense of great distance between the staff and the inmates in the two sections.

Although the majority of the male inmates the NPM spoke to felt safe in the communal sections, although around other inmates, several recounted episodes that led to them feeling anxious and unsafe. A higher proportion of the female inmates reported that they felt unsafe in the living units.

The Parliamentary Ombudsman emphasised in the last report to Bergen Prison that the prison had a duty to ensure safe conditions for the inmates in prison. The Parliamentary Ombudsman recommended that the prison administration implement measures to safeguard the inmates' safety in the communal sections, and to implement clear procedures for the presence of prison officers in the living units.

During the visit in 2018, the prison administration stated that internal guidelines for supervision in the communal sections were in place, but that the staffing situation had not improved. The prison administration had therefore changed the lock-up routines, based on, among other things, incidents in other prisons. The new procedures entailed the inmates being locked up in their cells when they came back from work or school, or during the periods the staff were on their breaks. More or less all of the inmates we spoke to were strongly opposed to the new procedures, with several arguing that more frequent lock-ups contributed to more frustration and conflict among the inmates.

Many inmates believed that it was the Parliamentary Ombudsman's report from 2014 that had led to the changes in the lock-up procedures.

Following the visit in 2018, the Parliamentary Ombudsman is still concerned about the staffing situation in Bergen Prison's communal sections. The fact that the correctional service is unable to safeguard the inmates' security by means other than increasing the time inmates are locked up in their cells is a cause for concern.

# 8 Health service

## 8.1 In general

The health service at Bergen Prison is organised under the health service in the City of Bergen. At the time of the visit, the health department had the following staff members:

- Doctors: 60 per cent of a full-time position (it must be noted that doctors were working 1.2 full-time equivalents, but only half that time was spent at the prison)
- Nurses: In total 7 nurses worked 5.9 full-time equivalents.
- Social educator: Full-time position
- Auxiliary nurse: 70 per cent of a full-time position
- Physiotherapist: 90 per cent of a full-time position

The health service was open from 7.15 to 21.45 on weekdays and from 9.00 to 16.15 on Saturdays and public holidays. If health services were required outside of these hours, the accident and emergency unit in Bergen had to be contacted. The health service was staffed by nurses, a social educator and an auxiliary nurse. Eight of them had specialised in mental health/psychiatry, and one in infection control. There was one male nurse. Normally, the health service was staffed by five people during the day, and two during the evening.

The health service also included a dentist working in 90 per cent of a full-time position, organised under Hordaland County Authority. The staff also comprised psychologists working 1.5 full-time equivalents and a psychiatrist in 80 per cent of a full-time position, employed in the specialist health service. Three doctors were employed at the prison, who each worked one day a week. The health service was staffed by one doctor on Wednesdays and two doctors on Thursdays. During the visit, the Parliamentary Ombudsman spoke to the head of the service and several members of staff, in addition to doctors and a psychologist from the specialist health service.

The doctor based at the prison, largely takes over the GP's responsibilities and duties in relation to the inmates.[43] The Directorate of Health's guide underlines that 'efforts should be made to ensure continuity in prison doctor positions'. [44] This is important both in relation to addressing the needs of every inmate and to ensure that the doctor is familiar with the special conditions and health challenges inmates may have. The doctor should also be familiar with the prison in order to be able to provide expedient medical follow-up to inmates. The doctors employed at Bergen Prison demonstrated expertise and continuity. However, it emerged that the doctors did not have a professional network, and nor did they receive much guidance. It also transpired that they use an outdated patient records system that may hamper the efficient, safer treatment of patients.

## 8.2 Admission interview

The health service stated that their priority was to carry out admission interviews soon after arrival. Ninety-eight per cent of the interviews were carried out during the first day, alternatively the following day if the inmate arrived late. If this was not the case, a nonconformity report was written. Three such nonconformities were recorded in 2017. The fact that the health service decided to

[43] The Directorate of Health (2016). Guide to health and care services for prison inmates. Oslo: The Directorate of Health

[44] Ibid. p. 32.

prioritise these interviews shortly after admission is viewed favourably. It is often in connection with such independent interviews and examinations that signs of abuse in police custody facilities or in connection with police questioning are uncovered. However, physical examinations were not carried out as part of the admission interview. The inmates were given an opportunity to take blood tests and they were informed that a doctor was available at the prison. The health service stated that they were not familiar with the UN's Istanbul Protocol.[45] This protocol provides important guidelines for requirements for documenting abuse. Neither did the health service have a camera available to document possible injuries. The health service was also unsure of where to report such injuries.

The health service used their own template to conduct admission interviews that contained questions about both somatic and mental health. Questions were also asked about the risk of suicide in the admission interview. The health service stated that this issue was addressed and carefully assessed during the interview. If a risk of suicide was identified, the health service recommended escorting the inmates to the accident and emergency unit.

The inmates confirmed that they were asked about the state of their mental health, and some of the inmates had also talked about the risk of suicide. Research shows that inmates often commit suicide during their initial period in prison, and early mapping of suicide risk is therefore important.[46]

**Recommendations**

- Health service staff should familiarise themselves with the Istanbul Protocol, and acquire expertise in uncovering abuse in accordance with the Protocol.
- The health service should have a camera available so that any injuries that the inmates may have can be documented by medical personnel in the patient records.
- The health service should ensure that suicide risk is always assessed in the initial admission interview.

## 8.3 Women's health

Men and women serve together in Bergen Prison. Female inmates are a particularly vulnerable group in many respects. Female inmates have more often than male inmates experienced sexual abuse, leading to trauma and feelings of shame and guilt. Many female inmates struggle with poor self-esteem as a consequence of a difficult childhood and traumatic experiences, including sexual abuse and prostitution. Women also have other health problems than men, and more women have infectious diseases. Research also suggests that the proportion of female inmates with severe substance abuse problems is higher than among male inmates.[47] [48] The inmates do not have the same opportunities as others to choose and, if applicable, change their regular GP. This limitation

[45] The Istanbul Protocol, Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
[46] Hammerlin, Yngve. *Selvmord og selvmordsnærhet i norske fengsler - selvmordsforebyggende arbeid i fengsel* ('Suicide and suicidality in Norwegian prisons – Suicide prevention work in prisons'). Correctional Service of Norway Staff Academy (KRUS), 2009 p. 57.
[47] The Correctional Service (2015) Likeverdige forhold for kvinner og menn under kriminalomsorgens ansvar
[48] Report No 37 Punishment that works – less crime – a safer society.

gives the health service special responsibility for designing solutions that help to ensure that inmates receive the medical care they need and are entitled to.

Negative experiences with men may make it difficult for women to receive proper medical care from male health personnel. Women's health challenges and the fact that women in prison may have a problematic relationship with their own bodies and health are the reason why the UN Rules for the Treatment of Women Prisoners, the Bangkok Rules, state that:

> If a woman prisoner requests that she be examined or treated by a woman physician or nurse, a woman physician or nurse shall be made available, to the extent possible, except for situations requiring urgent medical intervention. If a male medical practitioner undertakes the examination contrary to the wishes of the women prisoner, a woman staff member shall be present during the examination.[49]

There were only male doctors in the prison, and there was no possibility for female inmates to be examined or treated by a female doctor. Awareness of women's health was relatively low among the doctors in the health service. This is a challenge. The prison health service must address the inmates' general health needs and should not be limited to accident and emergency functions. From a preventive point of view, it is important that inmates do not refrain from consulting a doctor or giving an open description of their health problems because they find being open with a male GP problematic. It is also important to note that health problems may be experienced differently and as more urgent by people who are deprived of their liberty.

The health service otherwise appeared to be aware of the fact that women could be suffering from trauma, have more extensive substance abuse problems, and require more follow-up than male inmates. Nurses from the health service accompanied female inmates to gynaecological examinations with a doctor, and female inmates could ask to be accompanied by a nurse to other doctor's appointments.

**Recommendation**

- Steps should be taken to ensure that women who, for one reason or another, want a female GP have access to one.

## 8.4 Medication

The prison doctors prescribed medication.

The health service distributes medication in section A-øst and A-vest in the morning and evening. If an inmate in these sections required medication during the afternoon, it would be given to them by prison officers. The prison officers were responsible for distributing all medication in the communal sections. Medication was distributed from dispensers, which had been prepared by the health service. Prison officers who distribute medication must have taken a medication course. The health service has previously held medication courses for the prison, but no such courses have been held

[49] 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; Rule 10 No. 2.

recently. There may therefore be a risk of medication being distributed by prison officers without the necessary training.

The medication dispensers were marked with each inmate's name, but without any indication of which medication each dispenser contained. The health service stated that the dispensers containing medication that could be distributed when needed were marked with names. A receipt form had also been made, which inmates had to sign on receipt of ADHD medicine and group B medication. The reason for this was that inmates could ask for medication they claimed not to have received, and a system had to be established to document distribution. In previous visits to several prisons, the Parliamentary Ombudsman has criticised procedures that reveal the inmates' medication to staff who are not health personnel.[50] The use of medication is confidential information between the inmates and the health service, – and should not be shared with the correctional service. The current system, whereby information about which medication is required by the inmates is written on the dispensers, constitutes a breach of the health personnel's duty of confidentiality. Health service staff informed that the procedure had been developed on the recommendation of the pharmacy supervisor. However, the Parliamentary Ombudsman would like to emphasise that several prisons have systems in place which safeguard the inmates' right to confidentiality of their medical information.

**Recommendations**

- The prison should ensure that all prison officers who hand out medication have completed a medication course.
- In connection with the distribution of medication, the prison and the health service, in collaboration with a pharmacy supervisor, should ensure that medical information is not disclosed in a manner that is in breach of the duty of confidentiality for medical personnel.

## 8.5 Collaboration with the specialist health service

The specialist health service has its own prison health service section, with a permanent staff in the prison. At the time of the visit, there were five psychologist positions and one psychiatrist working 80 per cent of a full-time position. This represented stable expertise, where the professionals had been affiliated with the prison over time. The inmates could get in touch with a psychologist/psychiatrist through the doctor in the health service. The head of the prison health service section estimated that they received around four referrals a week, and that around 25 per cent were rejected. At the time of the visit, the waiting time for treatment was two months, but there were few people on the waiting list and no breaches of the time limit.

The section also functioned as a kind of emergency care service in the event of hospital admission being considered for inmates.

In addition to the specialist health service, the inmates can attend anger management programmes and sex offender treatment programmes. No referral is needed from a doctor to participate in these programmes – the inmates sign up and the correctional service decides who gets to participate.

[50] The Parliamentary Ombudsman's reports from visits to Telemark Prison, Kragerø and Skien branches, Tromsø Prison and Bergen Prison.

## 8.6 The health service's role in connection with exclusions from company (isolation)

Section 37 seventh paragraph of the Execution of Sentences Act states that a medical practitioner shall be notified of exclusions without undue delay.

All administrative decisions on exclusion from company reviewed by the Parliamentary Ombudsman, state that a medical practitioner should be contacted without undue delay. The health service stated that they were contacted if an administrative decision on exclusion from company was made during the health service's opening hours, and that they had an overview of all the inmates who had been excluded from company. When inmates were excluded from company in the evening or at night, the health service was informed the following day. However, it emerged that a doctor was never informed about administrative decisions on exclusion from company, but that the nurses in the health service carried out an evaluation. The Parliamentary Ombudsman would like to make reference to the Execution of Sentences Act and the Directorate of the Norwegian Correctional Service's guidelines, which clearly state that it is the prison doctor who should be contacted without undue delay after individual administrative decisions are made. A practice whereby nurses carry out an evaluation of which administrative decisions the doctors should be informed about, is not consistent with the law and should be changed.

As regards supervision of inmates excluded from company, the European Prison Rules state the following:

> 'The medical practitioner or a qualified nurse reporting to such a medical practitioner shall pay particular attention to the health of prisoners held under conditions of solitary confinement, shall visit such prisoners daily, and shall provide them with prompt medical assistance and treatment at the request of such prisoners or the prison staff.'[51]

The Mandela Rules also require daily supervision of inmates in solitary confinement. [52] The reason for this is that inmates in solitary confinement are considered to be particularly vulnerable to integrity violations. They have a limited opportunity to contact the health service, and, in some instances, are presumably unable to do so.

In its guide IS-1971 (2013), the Directorate of Health recommends that employees in the prison's health and care service visit isolated inmates when medical reasons so indicate.[53] This could be because the inmate requests this, or when information from the correctional service or others indicate that the inmate is in need of supervision. The same is reflected in the Guidelines to the Execution of Sentences Act.[54] The health service in Bergen Prison stated that the frequency of supervision varied based on needs, but that inmates in security cells were supervised at least once a day.

[51] The European Prison Rules, Rule 43.2
[52] The Mandela Rules, Rule 46
[53] The Norwegian Directorate of Health's guide (January 2013) *Helse- og omsorgstjenester til innsatte i fengsel* ('Health and care services for prison inmates'), page 44.
[54] Point 37.15 of the Guidelines to the Execution of Sentences Act.

**Recommendation**

- The health service and the prison should develop procedures that state that a doctor shall be contacted without undue delay in connection with administrative decisions on exclusion from company.

## 8.7 Access to health services and confidentiality

The CPT Standards for health services in prisons underline the importance of ensuring that inmates are able to communicate with health personnel in a way that safeguards confidentiality, for example by using a sealed envelope.[55] The importance of confidentiality of medical information also stems from the Mandela Rules[56]

Inmates could request contact with the health department by filling in a request form. The reason for the request was normally written on the forms. The health service stated that the request forms were only distributed in an envelope in exceptional cases. Books were available in the duty rooms in two prison sections, where inmates could request a medical consultation. It was also possible for the inmates to call the health service directly on the phone in their cells.

The design of the request forms means that the inmates end up sharing personal health information with others than the health service. It is thus important that envelopes are available, and that the inmates are made aware of the fact that they can hand in forms in envelopes. Request forms for medical consultations must never be read by prison officers.

The health service carried out most of the conversations and consultations with inmates in the health section. The inmates were escorted from their sections to the waiting room. The waiting room has glass walls, and people could look into the room both from outside and from the communal areas in section A-øst. This does not adequately safeguard the inmates' right to privacy. In addition, women could end up sitting on their own among many men while they were waiting for their appointment. This is unfortunate given what we know about the vulnerability of many women in prison. Reference is made to the fact that the Parliamentary Ombudsman already in 2014 pointed out that the waiting room did not take the inmates' right to confidentiality into account, and that the recommendation to amend this has not been followed. [57]

Most of the inmates who had been in contact with the health service stated that they were followed up reasonably quickly, but that it could take a long time to get in touch with a doctor. The inmates' level of satisfaction with the follow-up from the health service varied, but most were satisfied. Some of the inmates reported that a prison officer had been present during their consultation with the health service.

[55] The CPT Standards, page 39, paragraph 34. Reference is also made to the CPT's its visit to Denmark in 2014, [CPT/Inf (2014) 25], page
35, paragraph 53.
[56] The Mandela Rules, Rule 32 No 1 c.
[57] The Parliamentary Ombudsman's report after its visit to Bergen Prison 4–6 November 2014.

**Recommendation**

- The prison should ensure that confidentiality is maintained about all consultations with the health department's medical staff, including with the dentist, physiotherapist, psychologist and psychiatrist. The prison should ensure that request forms for medical consultations are always put in a sealed envelope

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