SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

SUMMARY AND RECOMMENDATIONS

Buskerud and Vestfold emergency youth centre, Barkåker

20–21 May 2019

National Preventive Mechanism against
Torture and Ill-Treatment

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1 Torture and inhuman treatment

The prohibition on torture and other cruel, inhuman or degrading treatment or punishment is established in several 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 connection. 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, which 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.

2 The Parliamentary Ombudsman's prevention mandate

As a result of Norway's ratification of the Optional Protocol to the UN Convention against Torture in 2013, the Parliamentary Ombudsman was issued with a special mandate to prevent torture and other cruel, inhuman or degrading treatment or punishment.[1] The Parliamentary Ombudsman has established its own National Preventive Mechanism (NPM) in order to fulfil this mandate.

The NPM regularly visits locations where people are deprived of their liberty, such as prisons, police custody facilities, mental health care institutions and child welfare institutions. The visits can be both announced and unannounced.

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

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

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

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

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

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

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

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

3 Summary

Barkåker is a state-owned emergency residential home for children in need of immediate care located outside the city of Tønsberg. It can house eight adolescents between the ages of 13 and 18, usually from the counties of Buskerud and Vestfold. The Parliamentary Ombudsman's National Preventive Mechanism (NPM) visited Barkåker on 20–21 May 2019.

Upon arrival at the facility the adolescents expressed that they felt they were well received. New residents are placed in an 'admissions apartment' before being assigned a room in the common residential area. Barkåker's written operating procedures gave the impression that residents were routinely held in this apartment for a specific length of time and would be refused access to common areas during this period. However, we found during our visit that Barkåker had changed its practice, and that restricted freedom of movement was no longer used as a matter of routine during the intake procedure.

During the visit it appeared as if the facility made extensive efforts to include residents, both as individuals and as a group. The adolescents said that they were well treated, respected and that they felt that they could speak up if they disagreed with something.

Our assessment of use of force decisions showed that a high number of these decisions had not been reviewed with the adolescents. We also found that several days often passed between implementing a use of force decision and reviewing the decision with the person concerned. In some cases, the review did not take place until several weeks after the use of force decision was made. This is problematic for many reasons, one being that it undermines the residents' right of appeal.

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

The unit did not have procedures for documenting that continuous reviews were conducted on whether it was necessary to uphold or discontinue a decision concerning restricted freedom of movement. Some decisions on restricted freedom of movement applied to both the interior and exterior part of the residential facility. This usually resulted in the adolescent staying inside an apartment which was located separate from the other residents. Although compensatory measures were put in place, this practice creates a risk of adolescents being isolated over a prolonged period of time from their peers and others who are not staff.

In most cases, adequate reasons were provided for administrative decisions concerning body searches and personal searches. We found that the staff and management had an awareness of how intrusive body searches can be. The threshold for conducting a body search appeared to be high. The NPM nonetheless found one example of a body search that did not safeguard the person's need for safety and dignity. Further, this body search was not conducted in a manner that ensured sensitivity to past trauma.

The exterior doors of the facility were locked, and residents who wanted to enter or exit the building were required to contact a member of staff to unlock the doors. Although findings indicate that residents who so requested were indeed allowed to leave, it seemed the standard practice of locked doors contributed to a negative interaction between the staff and residents. Locked doors as

standard practice during the day also raises some legal questions, specifically concerning adolescents who are placed at the facility on a voluntary basis.

In addition to the doors being locked, parts of the facility were shut off for several hours during the day. This reinforces the overall impression of restrictions at the facility. Even though Barkåker is an emergency residential home for children who need immediate placement, it should have the appearance of a normal residential care home for children.

Located inside Barkåker's administration building there was a so called 'isolation room'. This room resembled a police custody cell and appeared frightening and unfit to ensure the integrity and dignity of children and youth, and their sense of safety. Use of the room was to be limited to situations where use of force is necessary due to acute danger; if a situation did not de-escalate over time; and when other options had been exhausted. Our document review revealed that the room had also been used for body searches in the past year and a half. After our visit, we were informed that a new procedure was created, specifically stating that the room shall only be used in situations where the conditions for the use of force are met pursuant to Section 14 of the *Rights Regulation* (*Forskrift om rettigheter og bruk av tvang under opphold i barneverninstitusjon).*

Barkåker had recently conducted training in a so called "Safety and security programme" (Trygghets- og sikkerhetsprogram) developed by the Office for Children, Youth and Family Affairs (Bufetat). The programme focused on prevention and how to handle situations of acute danger. The programme did not appear to be very well implemented at the facility.

Our review of decisions concerning use of force revealed that information was often described in a very brief and simplified manner, specifically the part concerning review of the use of force incidents with both staff and residents. In addition, many of the records were not reviewed with the adolescents concerned, usually because they did not want to. It was therefore difficult to get a good understanding of their experience of the use of force. Other findings during the visit indicated that the use of force, and the situations leading up to the use of force, were subject to a an appropriate evaluation by staff and management.

During the visit, we learned that several adolescents with extensive mental health problems had been placed at Barkåker in the last few years, many of them over long periods. Several of these adolescents had harmed both themselves and others. This led to extensive use of force against some of them while they were residents at Barkåker. The staff said they felt that the number of adolescents with extensive, complex needs had increased, and expressed concern that the facility was not equipped to deal with this situation, neither in terms of staffing nor expertise.

The management at Barkåker confirmed that they felt they were under pressure from the police and others in regards to making decisions concerning use of force. As example, we found that one adolescent who had received decisions to restrict the use of electronic communication and restrict the freedom of movement were based primarily on police wanting to protect third-parties outside the facility.

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

3.1 Recommendations

Arrival

- Barkåker should update its standard operating procedures for intake and admission to avoid the risk of unlawful use of force as a matter of routine.

Use of force and restrictions

- Barkåker must ensure that decisions on the use of force are reviewed as quickly as possible after the decision is implemented, to safeguard the residents' right of appeal.
- Barkåker should review possible reasons for the extensive use of force at the facility. A comprehensive approach should be taken that includes the prevention of escalating situations.
- Barkåker should introduce procedures that ensure that decisions on restrictions are continuously assessed, and that this assessment is documented.
- Barkåker should consider, in consultation with superior authorities, to change the system of locked doors.
- Use of the isolation room should be discontinued.
- The facility and Office for Children, Youth and Family Affairs (Bufetat) should ensure that force is never used in excess of the limits provided for in the *Rights Regulations* and in accordance with what is considered reasonable.

Office address: Akersgata 8, Oslo
Postal address: P.O. Box 3 Sentrum, NO-0101 Oslo
Telephone: +47 22 82 85 00
Free of charge: +47 800 80 039
Fax: +47 22 82 85 11
Email: postmottak@sivilombudsmannen.no
www.sivilombudsmannen.no