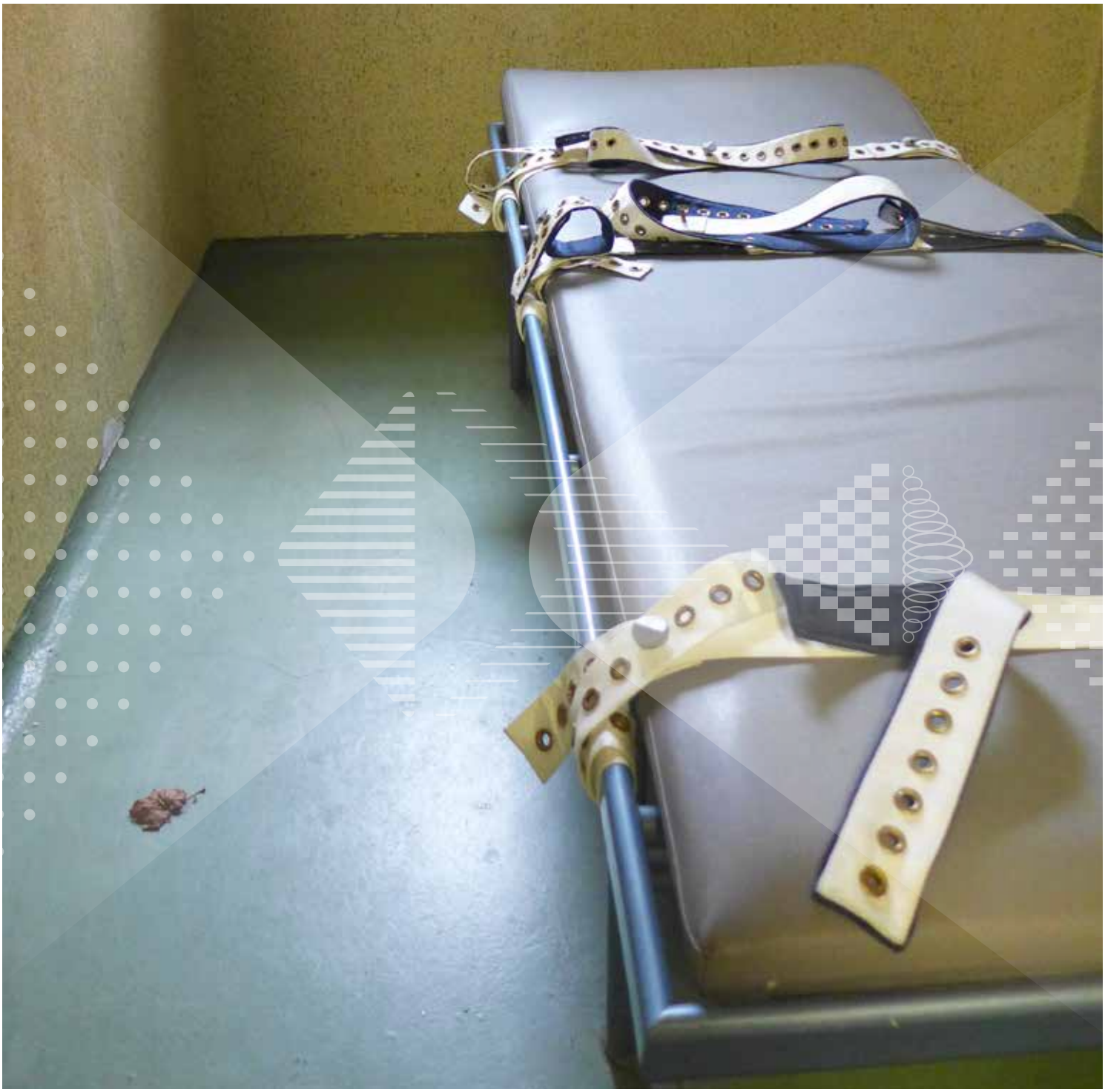

SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

# USE OF RESTRAINT BEDS IN NORWEGIAN PRISONS

Thematic Report 2020

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# The Parliamentary Ombudsman's Prevention Mandate

The prohibition against 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 ratified all these conventions.

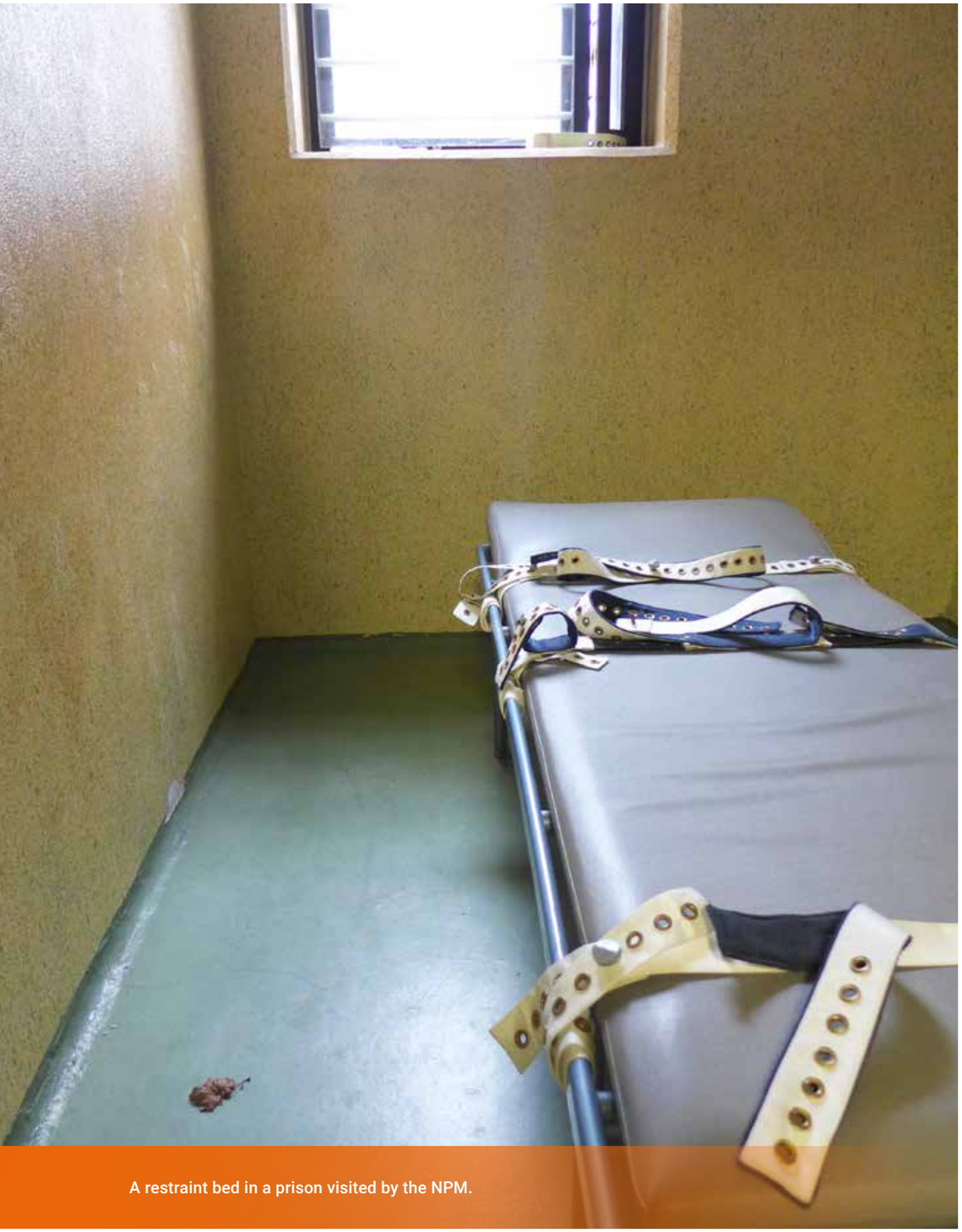
Individuals deprived of their liberty are sensitive to violations of the prohibition against torture and inhuman treatment, which is why the UN adopted an Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in 2002.

Norway ratified the Optional Protocol in 2013. It obliges the State parties to set up bodies to protect persons deprived of their liberty from torture and other cruel, inhuman or degrading treatment or punishment.[1] The Parliamentary Ombudsman was given this task, and a separate National Preventive Mechanism (NPM) was set up as part of the Parliamentary Ombudsman's office in 2014.

Under the OPCAT mandate, the Parliamentary Ombudsman has access to all places where people are deprived of their liberty and access to all necessary information with a bearing on the conditions of detention. The National Preventive Mechanism visits places 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.

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

1 Section 3a of the Parliamentary Ombudsman Act.



A restraint bed in a prison visited by the NPM.



## Thematic Report 2020

# Use of Restraint Beds in Norwegian Prisons

Strapping inmates into restraint beds is the most intrusive form of coercive measure at disposal in Norwegian prisons. Eighteen of the thirty-one high-security prisons in Norway have restraint beds. Being put in restraints can pose a considerable risk of both physical and psychological injury. During its visit to Norway in 2011, the European Committee for the Prevention of Torture (CPT) emphasised that removing restraint beds from Norwegian prisons should be a long-term goal. After its visit in 2018, the Committee further emphasised that the restraint beds should be removed from Norwegian prisons in its entirety.[1]

## 1 Introduction

Prisons can only use restraint beds to prevent inmates from harming themselves.[2] Being placed in a restraint bed involves being strapped into a bed that is permanently installed in a security cell. Police custody facilities no longer use restraint beds, and their use in mental healthcare institutions has long been debated. The Norwegian Official Report NOU 2019:14, *Draft Law on the Reduction of Coercive Measures* [Tvangsbegrensningsloven], was published in June this year and included a proposal to phase out the use of restraint beds in mental healthcare institutions entirely.[3]

The Parliamentary Ombudsman has criticised the use of restraint beds in prisons following several visits. In the spring of 2019, the Parliamentary Ombudsman submitted a Special Report to the Storting on Solitary Confinement in Norwegian Prisons.[4]

The purpose of the report was to make the Storting aware of the risk of violation of the prohibition against torture and inhuman treatment that solitary confinement in prison entails. The report concludes that the use of restraint beds in prisons involves a risk of harm to health, and that inmates placed in restraint beds are often exposed to trauma during an acute life crisis.

The Parliamentary Ombudsman has studied the use of restraint beds in Norwegian prisons in more detail over the past six months. This article looks at some of the most important findings and what they mean.

1 The CPT's visit to Norway in 2018, [CPT/Inf (2019) 1].
2 The Execution of Sentences Act Section 38 and the Directorate of Norwegian Correctional Service (2002). Guidelines to the Execution of Sentences Act and its Regulations, section 38.7. Revised version of 15 March 2019.
3 Norwegian Official Report NOU 2019:14 (2019). Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven].
4 Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons. Document 4:3 (2018/2019).

A restraint bed in a prison visited by the NPM.

## 2 Method

During the period 2014–2018, the Parliamentary Ombudsman's National Preventive Mechanism (NPM) conducted 20 visits to 19 high-security prisons. Based on these findings, the Parliamentary Ombudsman initiated an investigation into the use of restraint beds in Norwegian high-security prisons for the period 2013–2018.

We asked all of the high-security prisons in Norway to provide information on the number of restraint beds available and to submit the standard operating procedures for their use. We also asked for the total number administrative decisions on the use of restraint beds per year for the period 2013–2018; the duration of use in each decision; and how many decisions applied to the same individual. We conducted a review of all administrative decisions and the pertaining supervision logs.

The prison health service was asked to submit their written procedures for the use of restraint beds. We also asked for a description of how the health service is notified, their tasks in relation to the use of restraint beds, their role when the use is discontinued, and whether they conduct follow-up of inmates after being strapped in a restraint bed. All prisons and prison health services responded to our request for information.



## 3 Human Rights Standards and National Legislation

Restraints can only be used as a last resort, for the shortest time possible, and as the only way to prevent the person from inflicting harm on themselves or others.[5]

International law is moving towards a more critical stance on the use of restraints, in particular against people with mental health issues. The UN Special Rapporteur on Torture has recommended that the Member States discontinue the use of restraints entirely for people in that situation. The same applies to the UN Convention on the Rights of Persons with Disabilities.[6] The CPT has also previously recommended avoiding the use of restraint beds outside non-medical settings.[7]

The European Court of Human Rights (ECtHR) has in several cases established that restraints can constitute a violation of the prohibition against torture and inhuman treatment, cf. the European Convention on Human Rights (ECHR) Article 3. The Court currently appears to be applying a stricter review of cases concerning the use of restraints.[8] In its evaluation of whether a violation of Article 3 has taken place, the Court places particular emphasis on the requirements of documentation of adequate reasons, duration, measures that were attempted prior to the intervention and the type of supervision that was carried out.[9]

In Norway, the use of restraint beds is regulated by the Execution of Sentences Act Section 38. The Act provides for the use of restraint beds, security cells and other approved measures of restraint, in all situations covered by Section 38. This is not in accordance with the ECtHR's requirements that each decision to use a restraint bed is based on adequate reasons explaining why the decision was made. The Directorate of Correctional Service has specified in the guidelines on the use of restraint beds that this measure must only be employed when strictly necessary to prevent an inmate from harming him or herself.[10]

***'The decision was made on the basis that you took a butter knife and a razor blade and cut your left arm. You were then sent to the accident and emergency unit in an ambulance and you received several stitches. As the health personnel were trying to stitch up the wound, you tried to open the wound and prevent them from doing their job. Upon returning to prison, you were not communicative and not capable of describing what you wanted. For this reason, we assessed that it was very likely that you would continue to harm yourself. And you were therefore placed in a restraint bed.'***

From an administrative decision to use the restraint bed.

5 The Mandela Rules, CPT, Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012, section 86 and M.S. v. Croatia (no. 2, application no. 75450/12), judgment of 19 May 2015.

6 The UN Committee on the Rights of Persons with Disabilities (CRPD), Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities, adopted at the committee's 15th session in September 2015, paragraph 12 with further references.

7 See the CPT's visit to Germany in 2015 [CPT/Inf (2017) 13] on the use of Fixierung in prison.

8 Herczegfalvy v. Austria, application no. 10533/83, judgment of 24 September1992 (Chamber), Henaf v. France, application no. 65436, judgment of 27 November 2003, Wiktorko v. Poland, application no. 14612/02, judgment of 31 March 2009, Julin v. Estonia, application no. 16563/08, judgment of 29 May 2012, Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012, M.S. v. Croatia (no. 2, application no. 75450/12), judgment of 19 May 2015.

9 Henaf v. France, application no. 65436, judgment of 27 November 2003, Section 47.

10 Directorate of Correctional Service (2002). Guidelines to the Execution of Sentences Act and its Regulations, section 38.7. Revised version of 15 March 2019.

A restraint bed in a prison is inspected by the NPM.

Under Section 38 second paragraph of the Execution of Sentences Act, restraints shall only be used if the circumstances make this strictly necessary and less intrusive measures have been attempted unsuccessfully or are obviously inadequate. Restraint measures must be used with caution in order to prevent unnecessary harm or suffering. The guidelines stress that the Correctional Service will continually assess whether there is a need to uphold the measure.

In addition, the Act has rules for notifying a doctor and reporting long-term use of restraint beds to the governing authority, as well as separate, stricter rules for the use of restraint beds for persons under 18.

The health service's assistance to a person placed in restraints is regulated in the Health Personnel Act Section 4 concerning professional responsibility and diligent care.



## 4 Intrusive and Detrimental to Health

Being placed in a restraint bed is a major violation on personal integrity, and creates a risk of somatic injuries, trauma and other negative consequences to mental health.

Somatic risks include dehydration, circulation and skin problems, loss of muscle strength and mobility and incontinence. It also entails a risk of death as a result of blood clots.[11] Two fatalities have occurred during or after the use of restraints in mental healthcare institutions in Norway in the past 25 years: one as a result of a blood clot in 1998, and one due to cardiac arrest in 2011. In Denmark, a death was reported in 2016 as a result of a blood clot shortly after the use of a restraint bed in prison.[12]

*'The inmate claims that they have childhood trauma [...] and that the restraint bed reminds them of the trauma.'*

From the supervision log

We know that the use of restraints in mental health-care institutions pose a risk of personal injury. Such injuries can occur during the initial phase of the application of the restraint, due to lack of supervision, the inmate being placed in the bed for an excessive amount of time, or other reasons, such as body parts being trapped prior to application of the restraint, or aggressive behaviour from staff. In an attempt to control the inmate, the staff may overreact, thus leading to heavy-handed and painful use of force.[13]

The person put in the restraint bed will react with fear and panic, which is normal in this situation as he or she may feel that they are fighting for their life. Aggressive reactions from staff can result in conduct that escalates the conflict and constitutes a greater risk of injuries.[14]

There is also a considerable risk of negative mental health consequences. Feelings of powerlessness, helplessness, loneliness, fear and re-traumatisation are reported. In addition to the immediate harmful effects, being put in a restraint bed can lead to negative long-term effects, such as traumatising memories, feelings of mistrust and symptoms of post-traumatic stress disorder.[15] Studies also show that experiences of harmful coercive events are made worse when there is a sense of miscommunication in the situation, such as the feeling of not being taken seriously, humiliated or being punished. Such negative experiences can last for several years after the event.[16, 17]

11 Norwegian Official Report NOU 2019:14 (2019). Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven]. Oslo: Norwegian Government Security and Service Organisation, p. 267.

12 Ankerstjerne, (2018) Young man in restraint bed for 9 days in Vridsløselolle - died few days after release *[Ung mand lå fastspændt i 9 døgn i Vridsløselille - døde få dage efter],* TV2Lorry.no, 14. mars 2018. Available from: https://www.tv2lorry.dk/albertslund/ung-mand-la-fastspaendt-i-9-dogn-i-vridsloselille-dode-fa-dage-efter

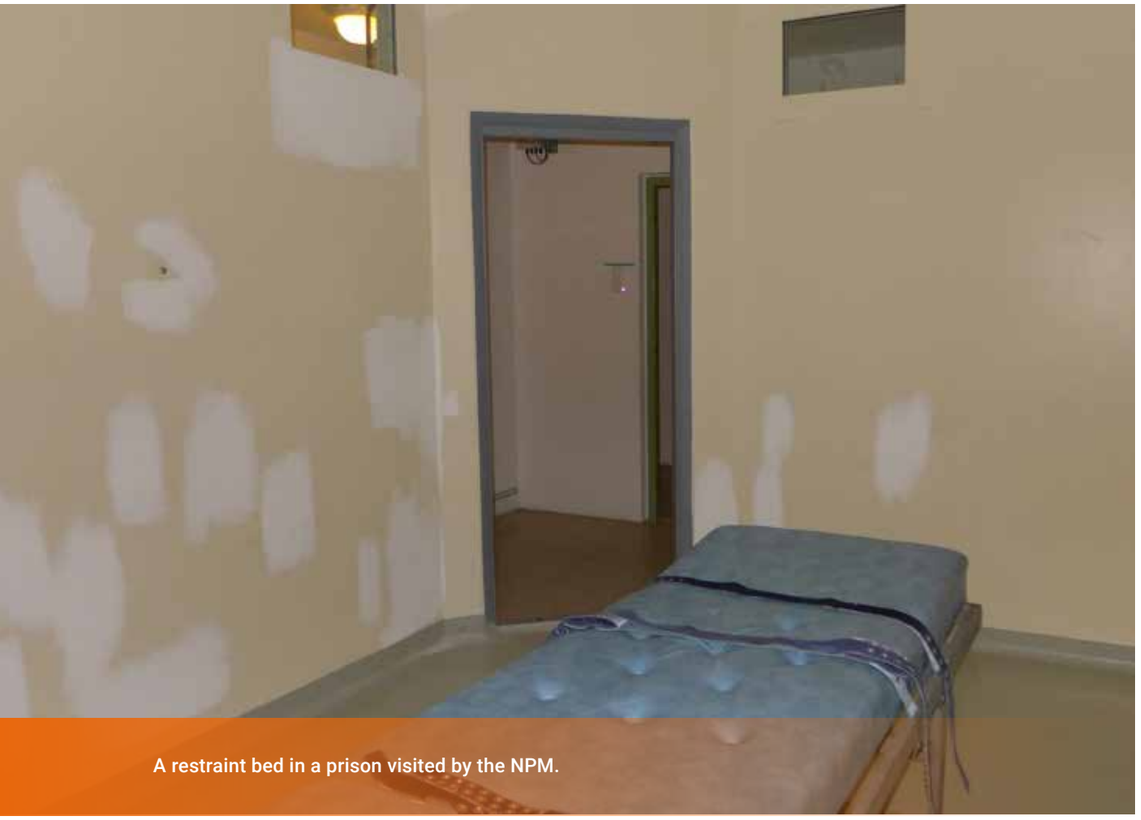
13 Norwegian Official Report NOU 2019:14 (2019). Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven]. Oslo: Norwegian Government Security and Service Organisation, p. 265.

14 Norwegian Official Report NOU 2019:14 (2019). Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven]. Oslo: Norwegian Government Security and Service Organisation, p. 265.

15 Norwegian Official Report NOU 2019:14 (2019). Draft Law on the Reduction of Coercive Measures [Tvangsbegrensningsloven]. Oslo: Norwegian Government Security and Service Organisation, p. 267.

16 Norwegian Official Report NOU 2011:9 (2011). More self-determination and legal safeguards. Oslo: Norwegian Government Security and Service Organisation, p. 124.

17 Strout, T.D. (2010). Perspectives on the experience of being physically restrained: An integrative review of the qualitative literature. International journal of mental health nursing, 19, 416–427.



A restraint bed in a prison visited by the NPM.

*'The inmate says that they are tired. Wants to try to sleep a little. When asked if the inmate would like some food, they answer that they are not sure. They are afraid of becoming more awake if they eat. They do not want to have a lot of energy while they are placed in the restraint bed. They might want to have something to eat later.'*

From the supervision log

Because inmates are placed in restraints when they harm themselves or attempt suicide, there is reason to believe that there is an increased risk of such long-term effects. It can thus be concluded that inmates who are placed in restraint beds are subjected to an intervention that entails a clear risk of developing trauma in an acute life crisis.

Neither the Execution of Sentences Act nor the Regulations define a duty of supervision. The guidelines as amended in March 2019, now require continuous supervision by prison officers.[18] The Correctional Service's guidelines previously specified that prison officers needed to check on inmates placed in restraints at a minimum of once per hour.

18 Directorate of Correctional Service (2002). Guidelines to the Execution of Sentences Act and its Regulations, section 38.7. Revised version of 15 March 2019.



## 5 Use of Restraint Beds in Norwegian Prisons

### Figures for the Last Six Years (2013–2018)

There are currently 31 high-security prisons in Norway. Of these, 18 have a restraint bed.[19] None of the prisons have more than one restraint bed. The prisons have stated that restraint beds in the period 2013–2018 were used a total of 82 times for 51 persons. During that same period, the figures have varied between 8 and 20 times per year nationally. In the past two years (2017 and 2018), restraints have been used 15 and 13 times respectively.

Of the 82 times restraint beds have been used, 27 cases concerned women, i.e. more than 30 per cent. During this period, the number of female inmates in Norwegian prisons has been approximately 6 per cent. It is not possible to conclusively establish the age of the persons placed in restraints, as the date of birth was lacking in 26 of the decisions we received.

Bredtveit Detention and Security Prison used the restraint bed 13 times in total during the period studied by the Parliamentary Ombudsman. Several cases concerned the same person. Bergen Prison used the restraint bed ten times in total for ten different people during this period. Åna Prison, Stavanger Prison and Tromsø Prison used the restraint bed nine times each during the period.

At all three prisons, the restraint bed had been used several times for the same inmate. The rest of the prisons used the restraint bed between one and five times throughout the period, and only two prisons stated that they had not used the restraint bed at all, including one of the juvenile prisons where the restraint bed was not approved.

The longest time spent in a restraint bed was three days and 19.5 hours, while the second longest time was two and a half days. Inmates were placed in restraints for approximately 40 hours in several of the prisons, and in thirteen cases for more than 19 hours. Twelve cases lacked documentation of the duration of the use of the restraint bed.

### Procedures in Prisons

Of the 18 prisons with a restraint bed, 17 submitted their written procedures for the use of restraint beds. Of these, eleven prisons had not revised their procedures for the use of restraint beds since the Correctional Service's new guidelines to the Execution of Sentences Act entered into force in March 2019 (the prisons sent their procedures to us during July and August). Of the six prisons that had revised their internal procedures for the use of restraint beds, two had not updated the procedures in accordance with the new requirements for the information to be included in supervision logs.

Poor procedures are demonstrated by the fact that approx. ten per cent of the incidents involving inmates being placed in restraints appeared to take place without an administrative decision. It is also demonstrated by the fact that many of the prisons lacked important information in both the administrative decisions and the supervision logs. Some supervision logs lacked documentation over a period of several hours. This is discussed in more detail under the subtitle *Restraint Beds and the Prohibition against Inhuman Treatment.*

### The Role and Procedures of the Health Service

Medical personnel must not be involved in decisions to use coercive measures, such as using restraint beds.[20] They are only responsible for safeguarding the patient's health and welfare in accordance with the 'primum non nocere' principle of preventing harm. The Nelson Mandela Rules set out detailed rules about

19 One of the prisons stated that it had an old restraint bed in the prison, but that the prison decided in 2016 to stop using it due to its age and standard. Another prison stated that its restraint bed is not approved, as is required, and has therefore never been used. The Directorate of Correctional Service has also stated that Arendal Prison, Evje Section, has ordered a new restraint bed.

20 The Mandela Rules, Rule 46 No 1.

A restraint bed in a prison visited by the NPM.

the role of medical personnel in relation to persons deprived of their liberty who are placed in solitary confinement, isolation or subject to other similar interventions.[21] Medical personnel should ensure regular medical checks of the inmates' physical and mental health, and report adverse effects to health.[22] The Health Personnel Act Section 4 states that medical personnel must perform their work in accordance with the requirements of professional responsibility and diligent care. Medical personnel play a key role in relation to inmates placed in restraints, both because the decision is made on the grounds of self-harm and risk of suicide, and because being placed in restraints in itself poses a risk of injury.

Inadequate supervision and medical follow-up of the inmates' health while placed in restraint beds could be aspects of an evaluation that may result in the conclusion that a violation of Article 3 of the European Convention on Human Rights has taken place.[23]

The health risks posed by being placed in restraints means that a qualified and accessible health service with solid procedures for follow-up during and after the use of restraints is essential.

For medical personnel to attend to their duties according to the Health Personnel Act, they must have in-depth knowledge of the risk of harm caused by the use of restraints. Half of the health services in prisons that have a restraint bed do not have dedicated procedures for their role and tasks when inmates are placed in restraint beds. Most prisons are also dependent on

21 The Mandela Rules, Rule 46 No 1, 2, 3.

22 The Mandela Rules, Rule 46 No 2.

23 Henaf v. France, application no. 65436, judgment of 27 November 2003, Section 47.



assistance from the local accident and emergency unit for large parts of the day when the prison health service is closed. Very often, inmates are placed in restraint beds in the evening and remain restrained throughout the night. In practice, the accident and emergency unit is rarely contacted, even when an inmate is placed in a restraint bed.

A review of the supervision logs showed that, in about half of the cases, a doctor was not consulted in advance, or notified as soon as possible, as set out in the guidelines.[24] Several of the supervision logs revealed that inmates spent many hours in restraint beds without being supervised by medical personnel.[25]

***'The inmate was placed in a restraint bed immediately after being admitted to the prison [...] on recommendation from the doctor.'***

From the supervision log

Prison officers also reported that doctors from the accident and emergency units were not very aware of the risks associated with placing people in restraint beds. As a result the prison officers would wait until the next day to notify medical personnel when prison health service staff were available.[26] In the majority of the cases, the doctors from the accident and emergency units do not have previous knowledge of the patients.

***'Tried admitting the inmate to hospital, but the hospital did not accept them.'***

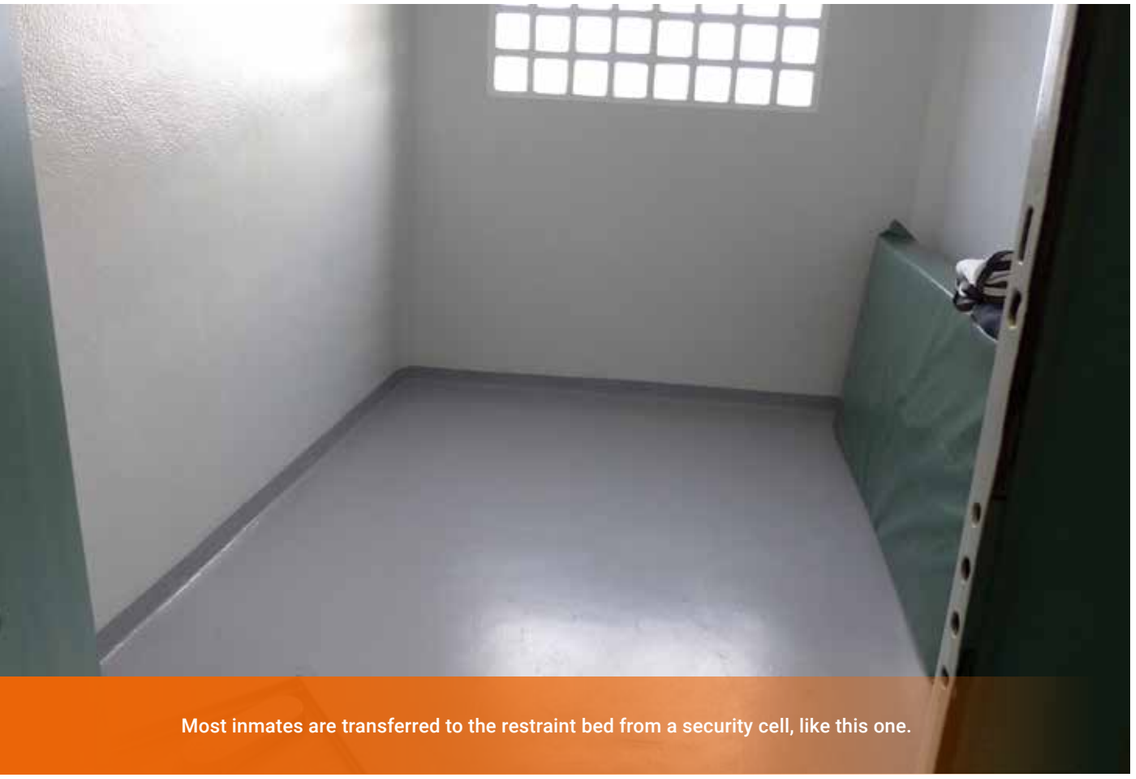
From the supervision log

As example, we found a description in a decision that an inmate had repeatedly banged his head so hard against the floor in a police custody cell and subsequently in a security cell that he sustained visible head injuries. The inmate said that he wanted to die and asked to speak to a psychiatrist or a psychologist. Despite several telephone conversations with the accident and emergency unit, the doctor on call decided not to come and attend to the patient in question, but recommended over the phone to the corrections officer that the inmate be placed in a restraint bed. The accident and emergency unit did not follow up and attend to the patient while he was in restraints, despite being informed of the fact that he was vomiting due to his head injuries. In another case, an inmate with known and extensive trauma due to sexual abuse over many years, was placed in a restraint bed following an attempt to harm himself after being placed in a security cell. According to the administrative decision, the prison's health service believed there was a major risk to life and health, and efforts were made to transfer the inmate to the specialist health service. After the health service closed, the inmate was assessed by a doctor from the accident and emergency unit, who concluded that the inmate did not wish to be in prison. The doctor confirmed to the inmate that he would remain in restraints until further notice.

24 Directorate of Correctional Service (2002). Guidelines to the Execution of Sentences Act and its Regulations, section 38.7. Revised version of 15 March 2019.

25 See, *inter alia,* the Parliamentary Ombudsman's report after its visit to Åna Prison, 13–15 November 2017

26 CPT/Inf (93)12-part Health care services in prisons, section 75: 'Prison doctors and nurses should possess specialist knowledge enabling them to deal with the particular forms of prison pathology and adapt their treatment methods to the conditions imposed by detention.'



Most inmates are transferred to the restraint bed from a security cell, like this one.

Our visits and review of documents have uncovered many weaknesses in the supervision provided by medical personnel. These are in contrast to the rules applicable to the mental healthcare service requiring continuous supervision by nursing staff when patients are placed in restraints.[27]

A decision regarding the use of restraints in compulsory mental health care can only be made by a doctor who is an approved specialist, or a clinical psychologist with the relevant practice and further education set out in the regulations. The decision can be appealed to an oversight commission (called Control Commission) independent of the hospitals.[28] The oversight commission must at its own initiative revise all decisions regarding restraints.[29]

There is increasing recognition in the mental healthcare service that self-harm and suicidal tendencies should not be met with coercive measures such as restraint beds, as this increases the risk of coercion being used rather than reducing the behaviour one wishes to prevent.

27 The Mental Health Care Act Section 4-8 fourth paragraph.
28 The Mental Health Care Act Section 4-8 fifth paragraph.
29 The Control commission's case processing, Circular, the Directorate of Health, 22 November 2016.



*'In the administrative decision, emphasis was placed on the fact that you banged your head into the brick wall, and that you were not responsive to our message that this was not good for you. You were therefore lifted up and placed in a restraint bed. The doctor from the accident and emergency unit came to the prison to assess you [and] did not admit you to the psychiatric department but said that you were receiving the treatment that was best for you at the moment.'*

From the supervision log

The role of doctors in connection with decisions to use restraints must be limited to advising against using such measures if there are health reasons for doing so. Our review shows that there were several instances where medical personnel recommended using a restraint bed. In some cases, the medical personnel also stated that supervision by medical personnel was unnecessary as the prison staff carried out continuous supervision.

This attests to a lack of understanding of the role of medical personnel, and a lack of knowledge about the adverse health effects of restraint beds.

The supervision logs also showed examples of both prison officers and the prison's health personnel attempting to get inmates placed in restraints transferred to a mental healthcare institution, but that this was rejected by the specialist health service.

## 6 Restraint Beds and the Prohibition Against Inhuman Treatment

### The Requirement of Strict Necessity

The ECtHR requires that the use of restraint belts must be necessary and proportional to prevent immediate harm.[30] According to Norwegian legislation, the use of restraints must only be employed when strictly necessary to prevent the inmate from hurting him or herself. The straps must be removed immediately when the risk of harm ceases. Less intrusive measures must always be attempted, unless it is obvious that they will have no effect.

*'02:08 – The blanket is starting to slide off. Says yes to having it put back on. Asks for another blanket, as they are cold.*
*[…]*
*05:16 – Inmate asks for help with the blanket. Asks for a regular pillow. The inmate is told that this is not possible.*
*[…]*
*05:33 – Complains about back pain. Says they want to move to the security cell to sleep.'*

From the supervision log

We found a significant number of decisions regarding the use of restraint beds that lacked adequate reasons. Several decisions lacked an individual description of the specific situation that made the decision necessary. In some prisons, half of the decisions lacked reasons for the use of restraint beds. In total, around half of the eighteen prisons had one or several decisions that contained inadequate reasons. No administrative decision has been made in eight of the 82 cases concerning the use of restraint beds.

30 Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012.

The lack of administrative decisions prevents the possibility for the inmate to file a complaint and limits appropriate internal control and oversight by external supervisory bodies. A lack of reasons for a decision also constitutes a threat to the legal safeguards of inmates.

*'Wanted to go back to the cell. [Officer] talked to the inmate. Must remain in the restraint bed until tomorrow. This is for their own good. Calm – accepts this.*

From the supervision log

The requirement of strict necessity applies to the entire restraint process. The ECtHR has established a violation of Article 3 in a case where an inmate, who was described as calm, was not released from the restraint bed.[31] This requirement has been violated in a significant number of cases where restraint beds have been used in Norwegian prisons during the past six years.

*'There is reason to be concerned that the use of security cells in reality can contribute to creating a situation that results in an inmate being placed in a restraint bed.'*

In two of the prisons, inmates were described as calm for most of the time spent in the restraint bed, in all the decisions made. In one prison, this applied to half of the decisions, while in other prisons this applied to several of the decisions.

During many of the incidents involving the use of a restraint bed, the inmates slept in the restraint bed. The Parliamentary Ombudsman has in several reports following visits to mental healthcare institutions criticised the fact that patients were asleep while in restraints, as patients who are asleep no longer constitute a situation where the requirement of 'strict necessity' is fulfilled.[32]

In some cases, the straps were loosened to let the inmate use the bathroom, make a call or shower, before being strapped back into the restraint bed. In these situations, an explanation was not provided for why the person should be placed in restraints again.

Most of the decisions lacked documentation that other less intrusive measures had been attempted before using the restraint bed. The supervision logs showed that most of the inmates were transferred to a restraint bed from a security cell. A security cell is an intrusive isolation and sensory deprivation measure. The Parliamentary Ombudsman has in several instances expressed great concern over the fact that people who are suicidal are placed in solitary confinement in security cells.[33] There is reason to be concerned that the use of security cells in reality can contribute to creating a situation that results in an inmate being placed in a restraint bed.

31 Julin v. Estonia, application no. 16563/08, judgment of 29 May 2012.

32 See, inter alia, the Parliamentary Ombudsman's report after visits to Østfold Hospital, psychiatric unit on 9–11 October 2018, Stavanger University Hospital, 9–12 January 2017 and Akershus University Hospital, emergency psychiatry department, 2–4 May 2017.

33 Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons, Report 4:3 (2018/19).



*'I called the accident and emergency unit for the second time and informed them that the situation had deteriorated. I found it uncomfortable to listen to a person banging their head against the wall. The doctor at the accident and emergency unit understood this but believed that there was no need to take the inmate to the psychiatric hospital in this case.*

*I further informed the doctor that the inmate was suffering from an increasing headache and was nauseous. The doctor responded that this was normal as they were banging their head against the wall. As I was talking to the doctor on the phone, [the prison officer] came in and said that the inmate had vomited. I communicated this to the doctor, who answered that this was also a reaction to the head being banged against the wall. I explained to the doctor that I had to take the inmate's safety into consideration and that it might entail the use of a restraint bed. The doctor consented to this.'*

From the supervision log

View into a cell equipped with a restraint bed through a surveillance mirror over the door to the cell.

### Duration

The ECtHR has in several judgments stated that the risk of a violation of Article 3 increases the longer a person is placed in restraints.[34] In a decision from 2009, the Court found that a violation of Article 3 had taken place in a case where a person had been placed in a restraint bed for 10 hours.[35] In a decision from 2012, the ECtHR found a violation of Article 3 in a case concerning a person being placed in a restraint bed for 9 hours. ECtHR stated the following:

*"Confinement to a restraint bed, […] should rarely need to be applied for more than a few hours […]"*

*and*

*"Having regard to the great distress and physical discomfort that the prolonged immobilisation must have caused to the applicant, the Court finds that the level of suffering and humiliation endured by him cannot be considered compatible with Article 3 standards".*[36]

Almost half (39) of the incidents concerning the use of restraint beds lasted for longer than ten hours. A significant number of these cases (13) lasted for longer than 19 hours. The supervision logs for 12 of the cases regarding the use of restraint beds did not contain information about the duration of these measures. The figures may therefore be even higher. In most of the cases, neither the decision nor the supervision logs provide any documentation as to why it was necessary to use the restraints for so long.

34 Julin v. Estonia, application no. 16563/08, judgment of 29 May 2012, Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012, M.S. v. Croatia (no. 2, application no. 75450/12), judgment of 19 May 2015.

35 Wiktorko v. Poland, application no. 14612/02, judgment of 31 March 2009.

36 Julin v. Estonia, application no. 16563/08, judgment of 29 May 2012.

*From the supervision log*

*'18:55 – The inmate banged their head harder and harder against the brick wall [...] was transferred to a restraint bed to prevent the inmate from self-harming. [...]*

*23:45 – Wakes up and says that they are cold [...] we loosen the left arm a little. Everything is OK.*

*00.00 – Changed the t-shirt as 2 hours had passed since the inmate had vomited [...] The inmate is very cooperative.*

*01:45 – Says their arms are aching [...]*

*02:00 – Says they are cold [...]*

*02:45 – Wakes up and complains about pain in both arms.*

*03:00 – Permitted to stretch their legs after complaining about pain in their legs. Loosened one foot at the time.*

*03:30 – Complained about pain in the arms. Permitted to stretch them one at a time. Was told to try to get some sleep.*

*03:45 – Says they cannot take it anymore. Wants to loosen one arm from the restraints for the rest of the night. Is told that this is not possible. Suddenly manages to free one of their arms. Is told to move it about now, because it is going to be a long time until the next time. This was ok. The inmate is calm and cooperative.*

*04:00 – The inmate keeps moving but is calm.*

*04:15 – The inmate is asleep, snores occasionally.*

*04:45 – Wakes up. Complains about pain in both arms.*

*05:15 – Complains that both arms are aching.*

*05:30 – [...] says their back is hurting, and that they have a prolapse. Asks what time it is. Says they can make it until the day shift arrives [...]*

*06:45 – Says they should have been examined by a doctor as they have been restrained for longer than eight hours.*

*07:00 – Managed to loosen one arm. Says they had to because they were in such pain.*

*07:05 – [Inmate is released from the restraint bed.]*

*The inmate was placed in restraints for a total of 11 hours and 50 minutes.*

## Supervision

Supervision is vital to preventing harm in these situations, and for ensuring a continuous assessment of whether the measure remains necessary. In its ruling from 2012, the ECtHR stated that one of the conditions that must be present in order to use a restraint bed is that checks are periodically carried out.[37]

Since 2019, the guidelines pertaining to the Execution of Sentences Act have outlined a requirement for continuous supervision in the event of the use of a restraint bed. The requirement was previously that supervision had to be conducted at least once per hour.

Many of the supervision logs showed more frequent supervision. Although most of the prisons underlined that continuous supervision was their established practice, this was not documented in the supervision logs.

During the Parliamentary Ombudsman's visits, we have learned that staff at some prisons are instructed to limit conversation with inmates placed in restraint beds. The reason for this is the idea that limiting human contact would ensure that the restraint bed does not become more attractive to inmates than the security cell. In one prison, the restraint bed was placed in a way that prevented the person in restraints from seeing whether anyone was keeping an eye on them. Such circumstances can reinforce the feeling of being powerless and isolated when the inmate is already subject to a highly intrusive measure.

Several of the prisons' supervision logs lacked information that could document whether and when medical personnel had seen the inmate.

## Inmates with Mental Illnesses

The ECtHR ruling from 2012 pointed out that people with mental illness are particularly vulnerable, and that this must be considered when determining whether Article 3 has been violated.[38]

We know from Norwegian studies that inmates in general have a high rate of mental illnesses.[39] When inmates are put in a restraint bed in order to prevent self-harm, this produces a clear risk of additional trauma and worsening of their mental health.

The UN Special Rapporteur on Torture points out that 'any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment'.[40]

One of the supervisory logs stated that the 'inmate had childhood traumas concerning restraint beds'. The inmate was nonetheless placed in a restraint bed. In another decision concerning restraint beds, it emerged that the person placed in restraints had been declared unfit to serve the sentence, due to extensive trauma after serious sexual abuse in their youth.

*'The inmate says they are psychotic and in pain. Unfortunately, we cannot help the inmate right now. Asked the inmate to try to sleep until tomorrow.'*

From the supervision log

37 Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012.

38 Bures v. the Czech Republic, application no. 37679/08, judgment of 18 October 2012, paragraphs 85 and 88.

39 Cramer, V. (2014). Forekomst av psykiske lidelser hos domfelte i norske fengsler. Oslo: Oslo University Hospital.

40 See the UN Special Rapporteur on Torture Juan Mendez's report to the UN Human Rights Council 1 February 2013, A/HRC/22/53, pages 14–15, section 63 and page 23, section 89 b).

## Other Conditions that Increase the Risk of Violations

*Clothing*
Very few supervision logs contained clear information about the inmate's clothing. The wording in several of the supervision logs suggested that inmates had been naked in the restraint bed. It has also emerged several times during the NPM's visits that inmates have been placed naked in restraint beds.

When placed in restraints, people are denied the possibility to defend themselves, and are therefore particularly vulnerable to abuse and inhuman treatment. Not wearing clothes in such situations increases this risk. It also reinforces the feeling of vulnerability and increases the risk of negative psychological effects as a consequence of being placed in restraints.

The revised guidelines have incorporated a requirement that the person placed in restraints must be clothed or his or her body must be covered. However, the new guidelines do not state that a person placed in restraints should never be naked.

In one of the supervision logs, an inmate was described as being restrained in a restraint bed without a tunic, even though she wanted to wear one. According to the supervision log, the inmate was told that personnel from the healthcare department would speak to her first. There were four members of staff in the room at the time, of whom at least three were men. No documentation showed that the inmate was covered by a blanket. The decision to give her a tunic was not made until one hour later. Other supervision logs also indicated that inmates were placed naked in restraint beds, in some instances with, and in other instances without, a blanket.

A restraint bed in a prison is inspected by the NPM.



Being strapped naked to a restraint bed with prison officers of the opposite sex in the same room, can be a very humiliating experience and increase the risk of trauma. It is important to underline that this can apply to inmates of both sexes.

*Gender*
Gender is a point of vulnerability. The UN Rules for the Treatment of Women Prisoners and Non-Custodial Sanctions for Women Offenders (the Bangkok Rules) underline the importance of good policies and regulations for staff working with female inmates.[41]

We know that many female inmates have been the victims of abuse and different forms of sexual exploitation.[42, 43] These are factors that can exacerbate the sense of humiliation from being placed in restraints. Over 30% of cases of inmates being placed in restraints in the period concerned women. This included some of the longest periods spent in restraints.

Additionally, the decisions analysed showed that female inmates who had been put in restraint beds, more often had been restrained several times, compared to male inmates who had been put in restraint beds. Five of the seven inmates who had been put in restraint beds four times or more, were women.

*Language*
A lack of opportunity to communicate with those the inmate depends on, is also a point of vulnerability. Foreign inmates are entitled to information in a language they understand.[44] The prison must ensure that the inmate has understood the grounds for the decision and understands the information that is provided. One of the supervision logs showed that the prison did not call an interpreter, although the inmate in the restraint bed requested an interpreter.

*Juvenile Inmates*
The threshold for placing juvenile inmates in restraint beds is higher than for adults – it must be 'absolutely necessary'. In one instance, a juvenile inmate remained strapped to, and at times, asleep in, the restraint bed for over 13 hours without medical supervision. This incident is mentioned in one of the Parliamentary Ombudsman's visit reports.[45] A review of the prison's procedures on the use of restraint beds also showed that they did not include separate points on the use of restraint beds in cases regarding juvenile inmates.

41 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.

42 Directorate of Norwegian Correctional Service (2015). Likeverdige forhold for kvinner og menn under kriminalomsorgens ansvar.

43 Report No 37 to the Storting (2007-2008). Punishment that works – less crime – a safer society.

44 The UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), adopted by the UN General Assembly on 17 December 2015, Rule 61 No 2. The recommendation of the Council of Europe's Committee of Ministers, Rec (2006) 2 to the member states about the European prison rules (The European Prison Rules), principle 38.3.

45 The Parliamentary Ombudsman's report after its visit to Bergen Prison 2–4 May 2018.

A restraint bed in a prison is demonstrated to the NPM.

## 7 Summary and Recommendation

The use of restraints in prison in order to prevent inmates from harming themselves or attempting suicide, raises important human rights and health-related questions. The revision of 82 decisions, alongside experience and the data collected from visits to several prisons, identified the following main issues:

### Risk to Life and Health

The use of restraints involves a risk of both somatic injuries, including fatal injuries, as well as a risk of trauma and serious psychological distress. Despite this, in most of the cases where restraint beds were used, they were used with minimal supervision by medical personnel. Qualified medical personnel are generally neither present at the start of nor during the time spent in restraints.



Inmates placed in restraints do not receive medical assistance from the specialist health service, but from the local accident and emergency unit or from the prison health service. Doctors from the accident and emergency unit do not have expertise in the use of restraints, and the review of the prison health service's procedures revealed major shortcomings.

On a national level, restraint beds were only used on an average of 15 times per year. This entails a risk that prison officers with little or no previous experience with restraints must use this highly intrusive measure on inmates in acute psychological crisis.

### Discrimination

The use of restraints to prevent people from harming themselves is a contentious issue. The UN Special Rapporteur against Torture has stated that persons with mental illnesses should not be subjected to such forms of coercion. The Parliamentary Ombudsman has in several visit reports and in the Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons, pointed out that solitary confinement in prison can increase the risk of suicide, self-harm and development of serious mental disorders.[46] Several of the cases where restraint beds were used seemed to result from precisely such a sequence of events; where suicidal inmates had been placed in solitary confinement and started to self-harm in the security cell.

People who are suicidal or have inflicted serious self-harm need medical assistance. If restraint beds in practice become a measure that prevents inmates from getting the medical assistance they require, the use of restraint beds can constitute discrimination and a violation of the inmates' right to receive medical assistance.

The fact that women are at a higher risk of being placed in restraints than men, and that they are more often put in restraints several times, raises additional questions about discrimination.  Inmates placed in restraints do not receive medical assistance from the specialist health service, but from the local accident and emergency unit or from the prison health service. Doctors from the accident and emergency unit do not have expertise in the use of restraints, and the review of the prison health service's procedures revealed major shortcomings.

### Lack of Legal Safeguards

Although the use of restraint beds is one of the most intrusive measures a prison can use, the quality of the decisions and supervision logs show significant shortcomings in the legal safeguards for those concerned. A large number of decisions do not explain why the measure was deemed strictly necessary, or document why the decision should be upheld, and there is no documentation stating that less intrusive measures have been attempted. These extensive shortcomings prevent a real possibility to file a complaint and raise major issues in relation to internal oversight. Many of the factors indicate a violation of the prohibition against inhuman treatment, set out in the UN Convention against Torture and the ECtHR Article 3 as interpreted by the European Court of Human Rights.

**Recommendations**

Based on these factors, the Parliamentary Ombudsman considers there to be a high risk of inhuman treatment in connection with the use of restraint beds and recommends that restraint beds be discontinued in prisons.

46 Special Report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons (Document 4:3 (2018/2019), pp. 66–67.

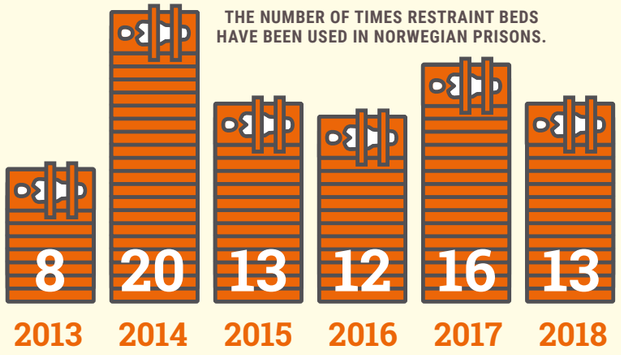
## Total Scope per Year 2013–2018

USE OF RESTRAINT BEDS
IN THE PERIOD 2013–2018

total of **82** times

on **51** persons

THE NUMBER OF TIMES RESTRAINT BEDS HAVE BEEN USED IN NORWEGIAN PRISONS.




## Duration

**39** of the times restraint belts were used, they were used for longer than **10 hours**

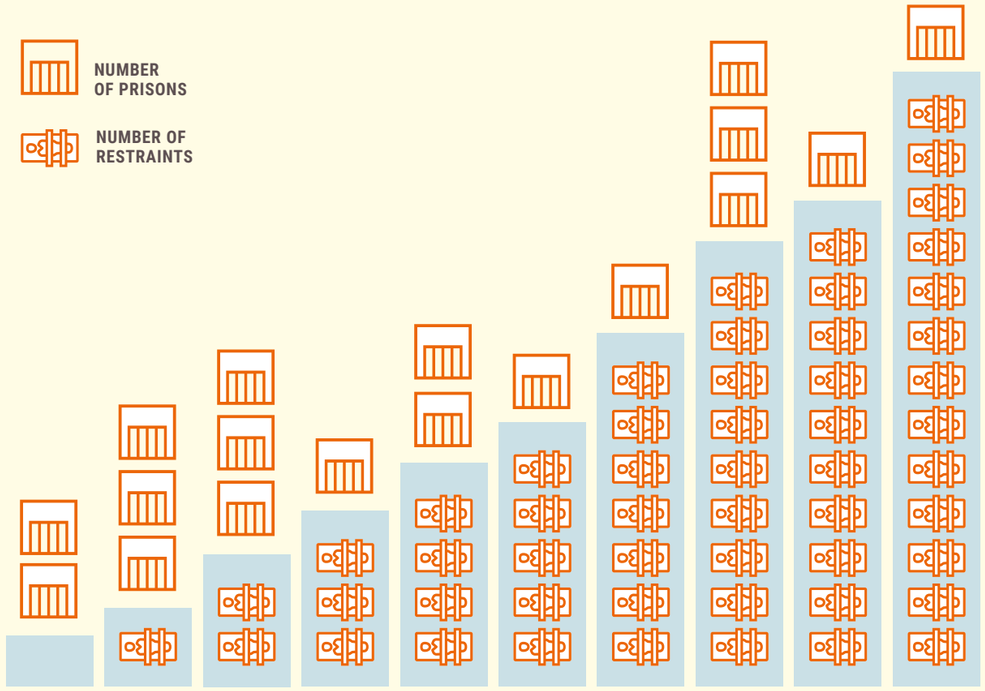
**13** of the times restraint belts were used, they were used for longer than **19 hours**

The **longest** time someone spent in a restraint bed was **3 days and 19,5 hours**

In several prisons, inmates were placed in restraints for approximately **40 hours**

**12** of the incidents of restraints were of **unknown** duration

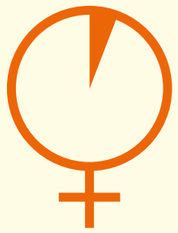
## Scope of the Use of Restraints per Prison 2013–2018




## Gender

**33 %**

27 out of 82 times restraint beds were used in the period 2013–2018, the inmate was a woman.



**6 %**

The total number of female inmates in this period has been approx. 6%.

**5,5x**

Between 2013 and 2018, female inmates were placed in restraints 5.5 times as often as male inmates.

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