SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

SUMMARY AND RECOMMENDATIONS

Stavanger Health Trust Division of Child and Adolescent Mental Health Care Services

8–10 and 29–30 October 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

The Parliamentary Ombudsman's National Preventive Mechanism visited the Stavanger Health Trust Department of Child and Adolescent Mental Health Care Services during the periods 8-10 October and 29-30 October 2019. We visited the department's inpatient ward for children and two inpatient wards for adolescents. The department was not notified of the dates in advance.

The Mental Health Act includes few regulations for children who have been deprived of their liberty. The hospitalisation of children under the age of 16 is not considered coercion as long as the parents or guardians provide consent. This applies regardless of whether it occurs against the wishes of the child. The fundamental rights listed in the UN Convention of the Rights of the Child have not been incorporated in this act. Regulations regarding the use of coercive measures against children and adolescents do not adequately address their vulnerable situation. Nevertheless, all hospitals have an obligation to ensure that children's human rights are respected, even if these rights are not specifically stated in the Mental Health Act.

Our findings indicate a positive development over the last few years, with increased focus on the involvement of children and adolescents. However, some of the adolescents still experienced limited opportunities for involvement in their treatment, and several staff members felt there was still a need to improve children's participation. The inpatient wards lacked good written information on the rights of children and adolescents, and several of the hospitalised children and adolescents were uncertain of their rights. In the children's ward, the children and their families had activities as part of their treatment. These activities were facilitated by milieu personnel and were adapted to the needs of the children. Activities were limited in the adolescent ward, and largely left to the families. The lack of recreational activities generally appeared to impact adolescents with no family members present, or those who had been hospitalised for a prolonged period.

The entire department was housed in one building. The children's ward facilities were in good condition and seemed pleasant. The adolescent ward had institutional atmosphere and more sterile surroundings than the children's ward. Several of the doors leading to the common areas and out to the atrium had to be unlocked by staff members. Each of the adolescent wards had a shielding unit. The design of these shielding units could be perceived as frightening and unsafe by vulnerable youths. Each facility consisted of a patient room with a toilet, a hallway, and a gateway between the patient room and a room referred to as a reinforced shielding room. These had no access to the lounge or common room.

The Parliamentary Ombudsman was particularly critical of the reinforced shielding rooms, which resembled isolation cells, and were entirely empty apart from a built-in bed with a plastic mattress. The rooms were devoid of normal sensory impressions. The windows were frosted, which prevented any view of the outside. The doors to the rooms had two round inspection windows. Such windows might give a strong sense of being monitored, increasing the likelihood that the room will be used for isolation. The sterile bareness of the rooms made it difficult to distinguish between its use for shielding and its use as a coercive measure. A review of the documentation indicated that several adolescents had experienced this room as highly unpleasant, and even frightening.

None of the adolescents we spoke with had ever been placed in a shielded room. Our findings indicate that most of the youth who had experienced time in shielded rooms were able to determine some of their activities and influence their treatment, and their needs were considered In some

cases, the youth stated that they had not felt safe and had not been treated with respect during their shielding period. A few adolescents experienced a particularly lengthy shielding period, due to repeated shielding decisions. A few had also been subjected to other methods of coercion and had spent part of their shielding period in one of the reinforced shielding rooms. In a few cases, they were there for several weeks at a time. This is completely unacceptable and poses a risk of inhumane and demeaning treatment.

The County Governor of Rogaland has earlier concluded that it is unlawful to use reinforced shielding rooms as living quarters. The County Governor issued an order to convert these rooms into regular rooms, and to ensure a more appropriate design for shielding facilities. Efforts to carry out the necessary changes should be a top priority for the clinic.

There was nothing to indicate that the children or adolescents present during our visit felt unsafe around the personnel, or that they were not well treated. Those we spoke with described the personnel as kind and caring. However, the department did not have common guidelines for how to prevent abuse and assault in the inpatient ward, or how to deal with suspicions of such cases. Our review of the documentation also indicated that previous hospitalised adolescents had not felt safe, especially those placed in the shielded units.

In the children's ward, children and parents were sent home on weekends, and the ward was unstaffed. In a few cases, younger children were transferred, along with their parents, to one of the adolescent wards for a weekend, because they were considered too ill to travel home. This was unfortunate and made these children feel unsafe.

In an earlier case, the County Governor commented on the unlawful use of isolation and mechanical restraints against a youth under the age of 16 in one of the adolescent wards. The department had made significant efforts to follow up the case, partly by providing better training. There were no other cases involving the unlawful use of restraints on children under the age of 16. Efforts are still needed to ensure compliance with the regulations. No decisions had been made in the ward on the practice of holding patients to prevent them from leaving the shielding areas. This is a flawed interpretation of the regulations. Holding a patient in a manner that restricts movement is only permitted in emergencies, in accordance with regulations on the use of restraints, regardless of where this occurs.

According to the clinic's statistics, the use of restraints and shielding has significantly declined over the last few years. Although these figures appear somewhat unreliable, they do indicate a general positive trend. Earlier adolescent wards used isolation more frequently than many of the adult psychiatric wards, and it is therefore important that the use of isolation was significantly reduced during 2019.

In some cases, the police used intrusive and forceful methods for bringing patients to the ward to have them hospitalised. Several of the staff members noted that the police had a low threshold for using handcuffs, and they had seen several adolescents with sore wrists from the handcuffs. On two occasions that police placed spit hoods over the heads of adolescents who were brought to the ward. The use of spit hoods on children is humiliating and can trigger anxiety and panic, especially in vulnerable children. These types of restraints involve a high risk of inhumane and demeaning treatment. In one of these cases, the hospital filed a complaint with the police.

Healthcare personnel can have a strong impact on the manner in which the police handle patients, both in general and in individual cases. It is essential to provide information on how these adolescents can be treated in a child-friendly manner, and what can be done to prevent unwanted incidents. At the time of our visit, there was no formal cooperative agreement between the department and the local police. Several people in management acknowledged the need for better dialogue with the police.

It was also reported that the supervisory commission did not follow a practice of visiting the children and adolescent inpatient wards to speak with them directly. It was more common for the staff to notify the commission if a child or adolescent wished to speak with them. The Ombudsman believes the commission has a duty to be physically present in the inpatient wards. This is a key element of the supervisory visits. Failing to do so will increase the likelihood that serious conditions in the inpatient wards will remain uncovered.

In light of the Ombudsman's findings, the supervisory commission should consider that the use of holding and immobilising a patient to maintain shielding may not be recorded in the decision and coercion register. Another important issue is the practice of checking the decision and coercion register entries in facilities where youth are subjected to repeated or lengthy coercion. There appeared to be some uncertainty as to what conditions were within the supervisory commission's area of responsibility, for instance, whether the commission could express opinions on the physical environment, including the shielding facilities. In the Ombudsman’s opinion, this should be a natural part of the commission's tasks, as a form of welfare supervision.

The County Governor of Rogaland has long had a practice of actively and thoroughly monitoring the use of coercive measures, such as the use of restraints and shielding in the adolescent wards Monitoring by the County Governor has contributed toward a greater awareness and knowledge of the rights of children and adolescent with respect to legal restrictions on the use of coercion. This will strengthen the efforts to prevent inhumane and demeaning treatment in facilities where individuals have been deprived of their liberty.

3.1 Recommendations

The right of participation

- Brochures on the rights of children and adolescents should be made available during the patient's stay, in a format adapted for the common areas of all inpatient wards.
- The department should ensure that written information is made available to children and youth and adapted to their needs. This information should include treatment, as well as rules and procedures in the inpatient wards.

Physical environment and activities

- The department should consult with the children and adolescents to ensure that the adolescent wards have a variety of activities adapted to each individual's level of function and interests.

Protection and safety

- The department should enhance measures to reduce the risk of violence, abuse and sexual assault agaist children and adolescents. These topics should be regularly discussed among the staff members.
- The department should look at alternative measures to ensure a safe environment for young children staying in the inpatient wards during weekends.

Shielding

- The department should ensure that all permanent and temporary employees receive thorough training on the use of shielding, as well as procedures in cases where patients actively resist shielding.
- The department should ensure a more humane layout of the area used for shielding. The rooms that resemble isolation cells should be converted to regular patient rooms, or be closed.
- The department should implement special measures to prevent the long-term use of shielding.

Use of coercive measures

- The department should ensure that neither necessity nor the right of self-defense is used as a legal basis for the use of coercive measures. It should also ensure that deviations from the provisions of the law are documented, reported and followed up by management.
- The use of mechanical restraints on children and adolescents should not occur. In high-risk, crisis situations, the department should ensure that such measures are terminated as soon as there is no longer any danger. A thorough documentation of all measures and assessments should be secured in accordance with human rights legislation.
- The use of isolation for children and adolescents should not occur. In high-risk, crisis situations, the use of isolation should only occur when strictly necessary, and be discontinued as soon as there is no longer any danger. Sufficient documentation of all measures and assessments should be secured in accordance with human rights legislation.
- The department should ensure that next of kin is always informed of decisions regarding coercive measures used in cases where the adolescent is not actively resisting, and that this is documented.
- The department should ensure that the practice of holding a patient is not used for the purpose of implementing or maintaining shielding, unless the requirements for the use of restraints have been met.
- The department should continue to work on securing a reliable overview of the use of coercive measures in the inpatient wards.

Coercive treatment

- The department should ensure appropriate assessments to determine whether the treatment of children and adolescents against their consent is strictly necessary, commensurate and justifiable.
- The department should ensure that the statutory conditions for coercive treatment are always justified in a concrete manner that enables a verification of these assessments.

House rules

- The department should review the house rules in the adolescent ward, to ensure that these fully respect the fundamental rights of children and adolescents.

The role of the police

- The department should improve its dialogue with local police and discuss the best possible treatment of children and adolescents when picking them up and upon admittance to hospital.
- If the department suspects that a child or adolescent has been subjected to inappropriate use of force by the police, it should ensure the proper documentation and report the matter. Serious cases should be reported to the Norwegian Bureau for the Investigation of Police Affairs.

Right of appeal and control measures

- The supervisory commission should make regular visits to the child and adolescent inpatient wards to ensure that their welfare and legal rights are protected, and to learn whether any of the patients wish to file an appeal. Some of these supervisory visits should be unannounced.
- The supervisory commission should thoroughly examine cases in which children and adolescents are subjected to significant coercive measures, and alert the County Governor of serious cases.
- The supervisory commssion should review its methods to ensure that it protects the welfare and legal rights of children and adolescents in a manner that is appropriate for their needs.

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