SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

SUMMARY AND RECOMMENDATIONS

Olivia Solhaugen, Hadeland

15.–17. januar 2020

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 Olivia Solhaugen's child welfare units in Hadeland in January 2020. Separate visits were made to the Myrheim and Storetjern units. Both units accepted adolescents ages 13 to 18, who were placed there on an involuntary basis. Myrheim was a long-term unit, where youth could be placed up to one year, with the possibility of an extension. Storetjern was an emergency care unit, where youth generally stayed no more than six weeks.

Both units had "live-in" staff shifts. The two units shared a professional manager and institution manager but had its own unit manager. Management was present and available in both units, and at the time of the visit, there was good stability and continuity among the staff. The staff members we spoke with appeared to be responsible, dedicated adults who talked about the adolescents with respect and dignity.

Each unit had its own institution plan adapted to its own target group. However, the units did use the same systematic work methods. The theoretical foundation and methods for the institution appeared to be well established for both units. The institution had focus on systematic competency building and training courses for its staff, with half-year training programmes for the entire institution and for each individual unit. Training was mandatory and staff was well informed about this. Olivia Solhaugen had a professional manager who was responsible for ensuring professional development, procedural development, systematic staff supervision and the development of training programmes and measures.

The institution had previously received criticism from the the County Governor and the Norwegian Directorate for Children, Youth and Family (Bufetat) for its lack of expertise and methodology in working with youth who had substance abuse problems. Neither of the units had youth with substance abuse problems as its primary target group, however, all child welfare institutions should have basic competency in recognising the risk of developing substance abuse problems and early intervention. In 2019, Olivia Solhaugen focused on courses and training in substances and substance abuse. However, this was not reflected in the institution plans, which lacked descriptions of methodology and competencies.

During our visit, we asked for an overview of the institution's use of coercion and administrative decisions on the use of coercion from 2019 through to the time of our visit in 2020. We also obtained coercion decisions for a longer period for youth who had had longer stays at the institution`s long term-unit, in order to look at developments in the use of coercive methods over time.

Olivia Solhaugen had its own template for administrative decisions for coercion, which had been approved by the County Governor. However, the Ombudsman assessed that this template had several shortcomings. The template did not include signature dating, nor did it state the time the decision was reviewed with the youth. It did not properly register the duration of coercive methods when these were used for a longer period, e.g. restrictions on freedom of movement. The template also lacked information about the date the youth were placed in the units, which made it impossible to know when during the stay a coercive method was implemented.

Both units we visited had made several decisions on the use of force in acute, high-risk situations during the time periods we looked at. Some of the decisions from these situations were poorly

documented and did not adequately explain why the staff had intervened in the situation. In a few of these cases, the actions of the staff appeared to escalate the situation, so that it resulted in aggressive behaviour. In some of the decisions it had not been adequately substantiated that the conditions for the use of physical force were satisfied. This applied to a few situations where the staff had used physical force to prevent material damage. Several of the decisions had failed to document whether less intrusive methods had been useless, clearly futile, or insufficient.

Olivia Solhaugen had no specific procedures for the prevention of coercion. There were, however, clear traces of the institution's efforts to prevent use of coercion in their procedures as well as in the institution's work with systematic training and supervision of staff members. In the units we visited, we learned that the staff spoke with the adolescents about the type of responses they preferred when experiencing problems, in situations that made them sad, stressed or angry ("triggers"), and about what helped to calm them in tense situations. This is information is essential for preventing unnecessary use of coercion. The units we visited differed in the extent to which this information was systematised and made easily accessible to staff.

Management was visibly active in the assessment of the institution's use of coercive methods, partly by providing written feedback in coercion protocols.

One unit had experienced situations where it was unclear whether an adolescent was permitted to move freely outside the institution. It was described that the staff had closely monitored an adolescent by constantly accompanying them, without a legal decision to permit this. It was our impression, however, that these situations did not occur often, and that the staff was aware of these grey areas.

Follow-up of adolescents after the use of coercion is essential in order to provide satisfactory care, secure the adolescents' legal rights, and to prevent further use of coercion. The institutions appeared to have good routines in place for this. In some cases, were adolescents had moved out, the administrative decision had not been reviewed together with the adolescent. The Parliamentary Ombudsman understands that this type of review may be difficult to manage during the process of moving but emphasises that the institution should do its utmost to ensure the youth's right to complain.

Overall, it was the Parliamentary Ombudsman's impression that the institution cooperated well with other facilities such as healthcare services, the police, and schools. This cooperation appeared to be characterised by dialogue and systematic cooperation at a management level. There were a few exceptions, where the adolescent had not been offered satisfactory educational services, or where they had been poorly received by the emergency medical ward.

3.1 Recommendations

Competency in substance abuse problems

- Olivia Solhaugen should update its institution plan to describe how the units work with substance abuse problems.

Documentation of coercion

- The institution should ensure that the template for administrative decisions on coercion are designed to secure that the document is notorised, to provide opportunities for adequate control of the use of coercive methods.

Coercion in acute, high-risk situations

- The institution should ensure that the conditions for the use of coercion in acute, high-risk situations are always satisfied, and that this is adequately documented.

Restrictions on freedom of movement

- The institution should ensure that routines and practices related to restrictions on freedom of movement are fully consistent with the child's rights and comply with the Child Welfare Act.

Following up the use of coercive methods

- The institution should prepare routines for ensuring the legal rights of the adolescents who have moved out.

The duty to prevent coercion

- The institution should ensure that all units maintain an overview of what might trigger aggressive behaviour, distress, anger, etc., and what might help to calm each adolescent. This should be easily accessible to all staff members.

Cooperation with healthcare services

- The institution should cooperatwith the local emergency meidcal ward to ensure the adolescents' right to healthcare services.

Right to respect for private life and confidentiality

- The institution should ensure that all procedures are prepared to ensure the rights of the adolescent in accordance with healthcare laws.

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