SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

SUMMARY AND RECOMMENDATIONS

Stendi AS, Nymogården Child Welfare Institution

12–14 November 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

Representatives from the Parliamentary Ombudsman's National Preventive Mechanism visited the Stendi Nymogården Child Welfare Institution from 12 to 14 November 2019. The institution was comprised of five departments with a total of six shared residential units. Two of these units were approved for placements of youth with severe behavioural disorders, pursuant to Section 4-24 of the Child Welfare Act, hereafter referred to as involuntary placements. Youth were placed in these shared residential units after decisions in accordance with Section 4-12 of the Child Welfare Act regarding care orders, hereafter referred to as care placements. The shared residential units were primarily ordinary residential houses that had been adapted to include a personnel duty room and separate bathrooms for staff members and the adolescents. Three of the houses for care placement youths were arranged around the same property, while the other houses were scattered in different directions, up to a 35-minute drive from Bardufoss.

The personnel group was constantly changing. This was particularly true of staff members working with involuntary placement youths. Many of the staff members were temporary workers, which made it difficult to maintain continuity and stability for these youths. Since there were numerous temporary workers and few permanent employees, it was difficult to compose shifts of regular teams. Numerous shifts also meant that staff members had little time to become acquainted with the youths, or plan activities with them.

Stendi Child Welfare Institution arranged several internal training courses for their staff members, including courses on the legal rights of the youths. Although the institution had its own educational and training programme in the prevention and management of acute crises, several of the staff members expressed that they felt uncertain of how to use physical force with youth in acute, high-risk situations.

Based on our findings, there is a risk that youths placed involuntarily at Nymogården will not encounter the same trauma-informed knowledge and competency as care placement youths. This is very concerning. The Ombudsman had the impression that youths with complex challenges were placed in units together with staff members that were neither prepared for, nor felt sufficiently competent to meet their needs. This appeared to result in a form of helplessness and inability to act among the staff members. Our findings during the visit gave cause for concern, in that the involuntary placement youths were given little opportunity to participate in both major and minor decision-making processes that involved them. It appeared as though the staff had significant difficulties in establishing cooperation with the youths.

The youths seemed to be aware of their right to file appeals with the County Governor, against both the use of coercion and other circumstances during their stay at the institution. During the visit, we learned that one of the youths had been denied private communication with an attorney, the County Governor, and the Parliamentary Ombudsman. Denying these adolescents their right to confidential communication with an attorney and appellant bodies is a serious infringement of their legal rights. It is especially concerning that adolescents who are placed involuntarily, and who also have restricted freedom of movement, are subjected to such intrusive control and practices.

Over the past several years, the institution as a whole has been placing increasing focus on avoiding confrontations, reducing and resolving conflicts, and withdrawing from acute, high-risk situations.

Descriptions of acute crises in the coercion register entries contained several examples of staff members who had attempted to deescalate the situation and prevent the use of coercive measures.

In two situations involving the use of physical restraint by holding the youth in 2019, we found evidence indicating that youths had been placed in a prone position. This use of this type of force involves an extremely high risk. Justifications for these two decisions were deficient. In both situations, it appeared that staff members had contributed to the escalation of the situation. One of the decisions were later discredited by the County Governor. This incident was thoroughly reviewed with most of the staff members, and the youth in question received an apology. Nevertheless, it is alarming that one staff member who was involved in both situations did not receive any feedback. Nor did this person participate in the review process afterwards. This lack of follow-up will only serve to increase the risk of future violations.

We found two examples from the past year where adolescents had been injured by the use of coercive measures at Nymogården. There were no procedures for reporting youth injuries in the deviation system. Management at the institution agreed that such injuries should be reported as deviations.

We met adolescents who had experienced continuous and extensive restrictions for several months, where such restrictions were part of a larger picture involving the significant use of coercion and control. A review of the 2019 protocol for decisions regarding restrictions on freedom of movement showed that many of these decisions were properly justified. However, there were also cases of decisions where it was difficult to understand why restrictions were necessary.

One decision to confiscate an adolescent's mobile phone was justified by the statement that the staff had not consented to being recorded. This justification does not satisfy the condition for restricted use that is "necessary based on the treatment programme or the purpose of the placement".

During the visit, four of the six visited units were housing only one youth. In our visits to other smaller child welfare institutions, we have seen similar examples of shared residential units with one youth living alone with a staff members. This may be a good solution for some adolescents. At the same time, it is obvious that such a measure, where one adolescent lives alone with staff members and no other youths, also poses a risk. Our findings during this visit confirm this. Some of the youths we met had minimal contact with peers, and little or no opportunities for schooling or activities. In sum, we find reason for concern. At the time of our visit, Nymogården had not managed to improve the isolating conditions for involuntarily placed youths in order to promote a good development for these adolescents. Such conditions may result in an infringement of children's rights as stated in the UN Convention of the Child and may involve a risk of inhumane and degrading treatment.

3.1 Recommendations

Cooperation with specialist healthcare services

- Stendi Nymogården and BUP (Child and Adolescent Psychiatric Services) in Silsand should make greater efforts to ensure that involuntarily placed youths receive appropriate assessments and treatment.
- Stendi Nymogården and BUP Silsand should also ensure supervision from BUP for institution personnel, in cases of adolescents with negative developmental patterns during their stay.

Security, stability and competency

- Stendi Nymogården should ensure stability and continuity among staff members in order to provide a better sense of security, as well as appropriate care and treatment for the youths.
- Stendi Nymogården should ensure competency enhancement for staff members at the Aspelund and Olsborgmoen units.
- Stendi Nymogården must ensure that all employees maintain a unified and safe approach to the management of youth in acute, high-risk situations.
- Stendi Nymogården should ensure that knowledge of trauma-informed care is utilised in the treatment of involuntarily placed adolescents.

Use of coercive measures in acute high-risk situations

- Stendi Nymogården should ensure that coercive measures are only used when absolutely necessary, and never beyond the boundaries of legal rights and regulations.
- Stendi Nymogården should ensure that holding and immobilising techniques to restrict movement, and other methods of physical restraints, are sufficiently documented in the decision protocol.
- Stendi Nymogården should establish routine procedures to ensure that injuries incurred by youths in acute, high-risk situations with staff members are consistently reported to the deviation system.

Restrictions on freedom of movement and contact with the outside world

- Stendi Nymogården should ensure the documentation of specific, individual assessments in all cases where restrictions on the freedom of movement and use of electronic communication devices are imposed on youth. These assessments must be justified in a manner that enables the youth and supervisory authorities to understand why the measure was considered necessary.

Confiscation of electronic communication devices

- Stendi Nymogården should ensure that its employees receive adequate supervision and training with respect to control measures that affect youths' private lives and electronic correspondence.

Infringement of the right to confidential communication with an attorney and appellant bodies

- Stendi Nymogården should ensure the protection of youths' legal rights and right to privacy. A youth's right to confidential contact with an attorney and appellant bodies must be fully respected.

Use of coercive measures based on caregiver responsibilities

- Stendi Nymogården should review its procedures for situations where the institution restricts a youth's freedom of movement, or determines other intrusive measures based on its caregiver responsibilities. These measures must be documented in the same manner, to enable the appropriate control by supervisory authorities.

Special risks for youth who live alone with adults

- Stendi Nymogården should, in cooperation with the contractor, ensure that involuntarily placed youth are cared for in facilities that have the appropriate competency to ensure and protect the youths' needs.
- Stendi Nymogården should ensure that the total situation for children living alone with adults does not involve subjecting them to unlawful isolation.

Evaluation following the use of coercive measures for preventive purposes

- Management must ensure that staff members who have been involved in the use of coercive measures in acute, high-risk situations also participate in a subsequent evaluation or other form of follow-up. This is particularly necessary when the coercive measure is defined as unlawful.

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