SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

SUMMARY AND RECOMMENDATIONS

# Group Homes for Adults with Developmental Disabilities in the Municipality of Drammen

**3.–5., 16.–20. and 23.–27. November 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

**Responsibilities of the Municipality**

The Parliamentary Ombudsman's National Prevention Mechanism (NPM) visited three group homes housing adults with developmental disabilities in the municipality of Drammen in November 2020. The group homes were of varying sizes, with the residents requiring different types of assistance and support. We examined the services offered and the conditions for a total of 20 adults with a developmental disability in the municipality. In all three group homes, there were residents who had been subjected to decisions on the use of force in accordance with Chapter 9 of the *Municipal Health and Care Services Act*.

The visits were conducted during the Covid-19 pandemic and adapted to comply with the infection control regulations in force at the time. Our visits included a brief inspection of one of the group homes, video and telephone interviews and document reviews.

People with developmental disabilities who reside in a group home have the same basic rights, as other people. They have the right to make decisions and maintain control over their own lives. Insofar as possible, the services offered at a group home are to be established in collaboration with the individual residents. Norwegian law does not have a special provision for the confinement of people with a development disability, but even so, in practice they may be subjected to extensive limitations. Many are also dependent on their living arrangements being facilitated to be able to live an unconfined and a good quality life. As such, persons with developmental disabilities are vulnerable to having their basic rights violated.

Our overall impression after the visit was that the municipality was in the process of improving their expertise in order to create comprehensive and quality services for the residents, especially in what was described as "*targeted social work and everyday coping*". The staff at the group homes appeared to have high awareness of the necessity to offer residents the possibility to make decisions and influence their daily lives. Both management and staff emphasised the significance of familiarity with each individual resident to be able to care for that individual as best as possible. The staff had implemented procedures for consultative meetings with next of kin and legal guardians of the residents. Most relatives of residents were satisfied with the level of involvement and contact. However, some of the legal guardians who were not also relatives, stated that they had not received sufficient information concerning the individual resident's living situation. There were limited procedures for cooperation aimed at safeguarding decision-making and self-determination for those residents who had a legal guardian appointed.

The municipality's course material on preventing use of force and the procedures for how to make decisions on use of force was of high quality. Meeting structures were established to follow up on the use of force and there was a focus on prevention. We found that there was both professional and ethical reflection on the use of force. Several staff members had undergone regular training on defensive techniques. Most of the staff said they received sufficient training and guidance on the use of force measures and seemed to have a high level of awareness that the use of force should be avoided as much and for as long as possible. Even so, the visit revealed several aspects that demonstrated a lack of knowledge about the legal requirements and compliance with regulations concerning use of force decisions.

As part of our visits, we reviewed all decisions on the use of force in emergency situations over a two-year period up to the date of the visit, as well as all decisions related to prolonged use of force dating back to 2015. Several of the decisions contained adequate information and detailed

descriptions of the background for using force and which alternative measures were attempted prior to using force.

Our review concluded that several decisions were not substantiated in accordance with the legal requirements for using force. This applied to several residents who had been subjected to extensive use of force measures over several years. We noted that the decisions lacked reasons describing why applying the restraint was necessary. Inadequate justification for using invasive force is highly problematic in light of human rights requirements and undermines the importance of due process for the individual resident concerned. It is the responsibility of the Government to document and justify that the use of force measures was a last resort option and that the conditions for necessity and proportionality have been met. According to the Parliamentary Ombudsman's evaluation, several of the measures did not meet these requirements.

When the decision is made to use force, the person concerned must be involved in that decision in order to explore measures and methods that will be experienced as the least invasive. Legal guardians and relatives are key due process participants and are to be involved in the decision-making process in collaboration with the resident. Several of the decisions contained limited information on the views of the resident, legal guardian or relatives in relation to the use of force measure. The findings indicated that the municipality should work more systematically to obtain and document information on the needs and desires of residents. This also includes involving relatives and legal guardians more in efforts to prevent the use of force.

The review also revealed that use of force measures were implemented for several residents without the decision having been approved by the County Governor. Among the residents who were subjected to use of force decisions over many years, we found several examples of measures being sustained even after the statutory period had expired. In several of these cases, this was due to a delay in submitting the decision to the municipality for review. In some cases, due to delay in processing times at the County Governor's Office residents were subjected to use of force decisions for long periods without having the necessary legal authorisation. At the time of the visit, one resident had been subjected to several invasive use of force measures over a period of two years and eight months without an actual legal decision. Another resident experienced several use of force measures implemented for a period of almost seven months without any legal decisions. These measures included the use of mechanical restraints that restricted freedom of movement.

The Parliamentary Ombudsman considers it a serious violation for residents to be subjected to unauthorised use of force measures, especially considering these were repeated and lasted for long periods of time and involved physical restraints. This practice violates the basic principles of due process, prevents complaint mechanisms and oversight, and is contrary to the Human Rights requirements that decisions on use of force contain adequate reasons and are sufficiently documented.

In all of the group homes we found measures used that were described as seclusion. During the visits we discovered that some staff members were unsure when seclusion was considered a use of force measure and when it was not. Our review also revealed that seclusion was implemented without a legal decision, even though it was considered a use of force measure. During the seclusion of one resident we learned that the resident was locked inside the apartment alone for several hours during the day and over the course of many days. In addition, the apartment was bare and with few furnishings and showed signs of wear and tear and destruction. Sometimes staff used a chain on the door while visiting with the resident to prevent the resident from going to the common area. The decision to use seclusion and a locked door lacked authorization and there was no recorded

documentation on the necessity and proportionality of the decisions to implement these force measures. There appeared to be a high risk of violating the rights of the resident.

Every individual has the right to the highest possible standard of health, both physically and mentally. People with developmental disabilities can have difficulty communicating their health needs and identifying signs of illness, and their symptoms may manifest differently than in the rest of the population. Untreated pain and other health issues can result in disruptive behaviour, which in turn can lead to increased decisions to use force. Adequate and appropriate medical care is therefore important to prevent use of force. Our findings showed that responsibility was taken to ensure good medical care in general and that the residents underwent regular health checks. However, several staff members expressed a lack of sufficient knowledge or guidance on how to monitor the residents' mental health. Several residents were medicated to reduce anxiety and challenging behaviour. The group home walks a thin line between using medication to cope with challenging behaviour and making decisions to use force, even if the resident has given consent to use the medication. The records showed that one resident was medicated often, sometimes daily. The recorded description of events and assessments in connection with the medication were very brief. Although a medical specialist was consulted prior to prescribing sedatives in this case, the Parliamentary Ombudsman is concerned about the extent of usage and how the medication affected the everyday life of the resident.

Persons with a developmental disability are at an increased risk of neglect, physical, mental and sexual abuse, as well as financial exploitation. The municipality must facilitate the health and care services so that they can focus on preventing and identifying abuse against its residents. During the visits, we found that many staff members who worked directly with residents were unaccustomed to discussing the vulnerability of mentally disabled persons to abuse. Nor were they aware of how to prevent, recognise and report abuse. We determined that the municipality need to improve and work more systematically to increase staff awareness of the risk factors linked to abuse of mentally disabled persons.

### Responsibilities of the County Governor

The decision to use force must be reviewed by the County Governor's Office and may not be implemented until it is approved. The County Governor's oversight is essential to ensuring due process rights. During our visits we reviewed appeal decisions for several residents in the period 2015–2021. Several of the appeals contained concrete discussions and assessments in terms of whether the legal requirements were fulfilled. However, we also found several examples where the appeals were superficial and vague and lacked adequate documentation of assessing whether the legal requirements were fulfilled. The appeals contained standard formulations without individual assessments and consisted primarily of referrals to municipal decisions without any further comments. This raised doubts as to whether the County Governor had conducted its own independent assessment. Moreover, several of the decisions lacked sufficient information to assess whether the conditions for the use of force were fulfilled, even though the County Governor had approved the decision.

Several appeal decisions lacked documentation that the views of the resident and the resident's representative had been considered. It is worrisome that we found examples where the County Governor approved the use of force decision, even though a special legal guardian had not been appointed as is required in Chapter 9 of the legislation. These circumstances weakened the legal rights of the resident and increased the risk of illegal force being used.

In order for the County Governor's oversight responsibilities to be effective, due process rights, such as the requirement that decisions are made within reasonable time, need to be adhered to. In several cases, we noted that appeal decisions took several months. Our visits revealed that in the meantime, the residents were subjected to extensive use of force measures, without authorisation. It is very concerning that neither the municipality nor the County Governor has prioritised cases in which a person has been subjected to invasive force without authorisation.

## 3.1 Recommendations for the Municipality

**Appointment of a Special Legal Guardian:**

- The municipality should demand that a legal guardian with a mandate in accordance with Chapter 9 of the *Municipal Health and Care Services Act* be appointed the moment the municipality considers it relevant to make a decision on the use of force.

**Cooperation in the Decision-Making Process:**

- The municipality should ensure and document that the residents, relatives and/or legal guardians have been actively involved and heard during the decision-making process.
- The municipality should ensure that the person with professional responsibility for the service, the County Governor, the legal guardian and the next of kin receive immediate written notification of the decision to use of force in emergency situations.

**Content and Justification of Decisions:**

- The municipality should ensure that the decision to use force is in accordance with the requirements in Chapter 9 of the legislation, including adequate reasons and individual assessments and information that clearly document that the conditions for the use of force have been met.

**Repeated or Prolonged Emergency Situations:**

- The municipality should ensure that a continuous need to use force (prolonged emergency situations) is identified without undue delay, so that a decision can be made and reviewed by the County Governor as soon as possible.

**Use of Illegal Force:**

- The municipality should ensure that force is not used repeatedly or in prolonged emergency situations without a decision that has legal authorisation.
- The municipality should ensure that new decisions are sent to the County Governor without undue delay and that decisions that are not authorised by the County Governor are followed up on immediately and resubmitted for review.
- The municipality should ensure that the procedure for making decisions to use force in emergency situations are done in accordance with Section 9.5(3)(a) of the legislation until the decision is authorized in accordance with Section 9.5(3)(b).

**Seclusion in Group Homes:**

- The municipality should ensure that residents are not prevented from leaving their home (secluded) until a decision to use force is made and all legal requirements are fulfilled.

- The municipality should ensure that the use of seclusion measures are always documented so that it is possible to assess whether the conditions of necessity and proportionality are fulfilled.
- The municipality should implement special measures to prevent prolonged or invasive seclusion. Measures should also be implemented to ensure that the seclusion room is an appropriate location and that it does not increase the burden of the seclusion.
- The municipality should conduct an assessment of whether the living conditions and locations of the homes are suitable for each individual resident and assess whether the conditions in the home or living situation lead to an increased use of force.
  Use of Force in Care Situations:
- The municipality should ensure that force is not used without authorisation and that this measure is necessary and proportional.

**Insufficient Records:**

- The municipality should ensure that records are sufficient and detailed enough to allow for monitoring and oversight.

**Staffing for Residents with Special Needs:**

- The municipality should ensure that residents with special needs are cared for by staff members with the right expertise and skills.

**General Restrictions of Freedom of Movement:**

- The municipality should ensure that the residents' general rights to freedom of movement are respected.

**Inadequate Self-Defence Training:**

- The municipality should ensure that all staff members undergo regular and high-quality training on legislation concerning the use of force and receive instructions on how force can be prevented.
- The municipality should ensure that all staff members undergo education and awareness training on conflict management and the use of defensive techniques.

**Use of Medication to Manage Challenging Behaviour:**

- When administering sedatives, the municipality should verify that they are not administered over longer periods of time without first having assessed the overall treatment options for the resident.

**Protection from Violence and Assault:**

- The municipality must implement measures to increase staff member awareness and knowledge about abuse and assault to enable them to recognise such incidents.
- The municipality should investigate whether all relevant residents have received sexual health education and guidance.

## 3.2 Recommendations for the County Governor

**Appointment of a Special Legal Guardian:**

- The County Governor should ensure that decisions to use force are never authorised without documentation that a special legal guardian has been appointed with a mandate that includes the responsibilities stated in Chapter 9 of the *Municipal Health and Care Services Act*.
- The County Governor should ensure that the legal guardians appointed undergo sufficient training.

**The Views of Residents, Relatives and Legal Guardians:**

- The County Governor should ensure that the views of the resident and the resident's representative are assessed as part of the appeal and that this is clearly stated in the decision.

**Justification on the Use of Force:**

- The County Governor should ensure that sufficient and verifiable justification is provided on the decision to use force.

**Case Processing Time:**

- The County Governor should ensure that decisions are reviewed within the applicable deadline and that decisions concerning invasive use of force without authorization are reviewed within a reasonable time. They should also ensure that the municipality receives the necessary guidance.

**Documentation and Follow-Up:**

- The County Governor should ensure that requirements previously established by the County Governor for authorizing decisions, are followed-up.

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