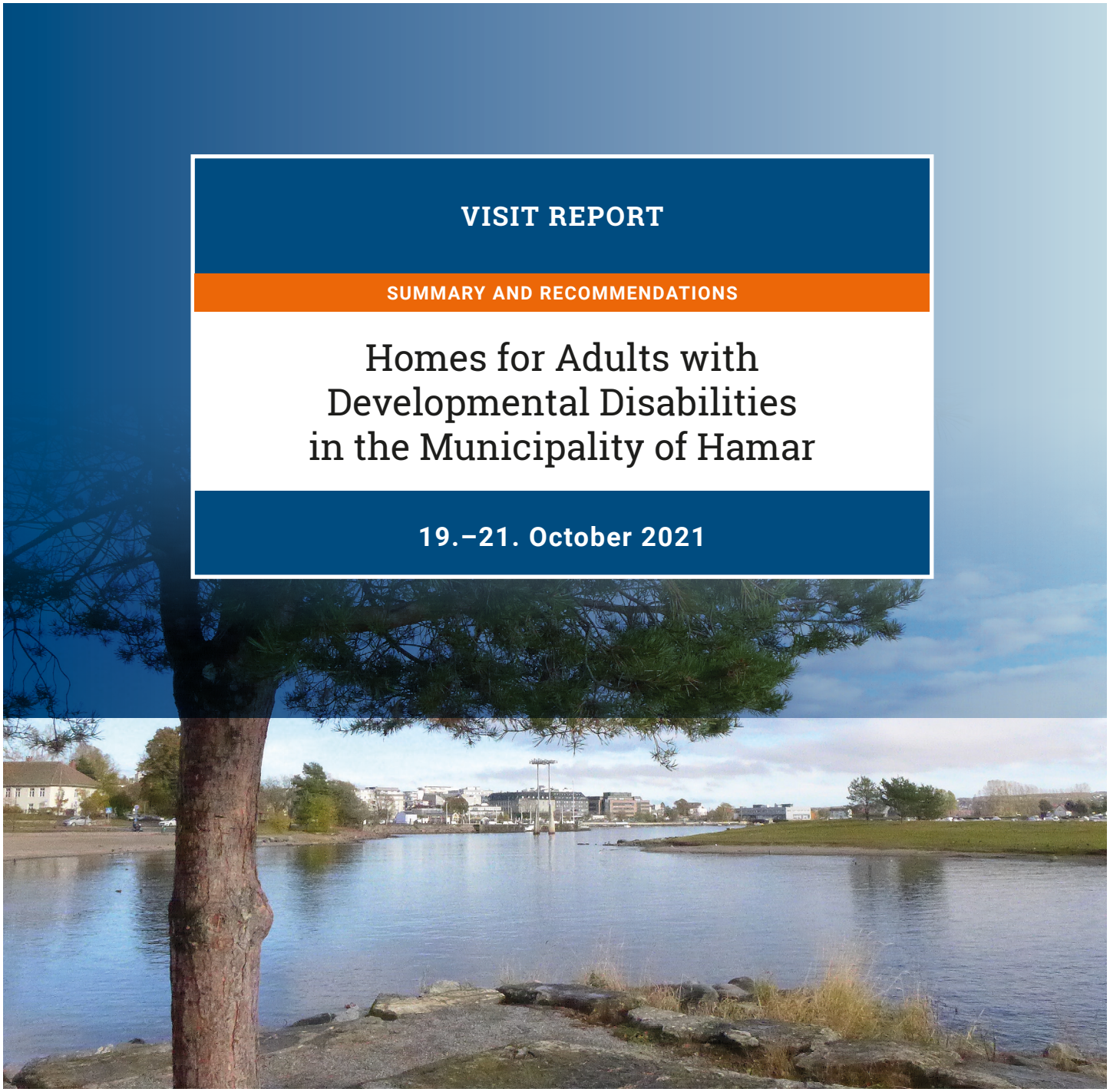
SIVILOMBUDET
Norwegian Parliamentary Ombud



VISIT REPORT

SUMMARY AND RECOMMENDATIONS

Homes for Adults with Developmental Disabilities in the Municipality of Hamar

19.–21. October 2021

National Preventive Mechanism against
Torture and Ill-Treatment

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I. The Parliamentary Ombudsman's prevention mandate

The prohibition on torture and other cruel, inhuman or degrading treatment or punishment is established in several international conventions that are binding for 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. The same prohibition is also embodied 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 of 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.

The protocol requires that states establish bodies to ensure that persons who are deprived of their liberty are not subjected to torture and other cruel, inhuman or degrading treatment or punishment.[1] The Parliamentary Ombud has established its own national preventive mechanism (NPM) in order to fulfil this mandate.

The Parliamentary Ombud has access to all locations where persons are or may be deprived of their liberty. These range from prisons and police custody facilities to mental health care institutions and child welfare institutions. Visits are conducted with or without prior notice. The Parliamentary Ombud also has access to all necessary information of significance for how deprivation of liberty is implemented.

The risk of torture or inhuman treatment is affected 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 focus exclusively on whether the situation complies with Norwegian law.

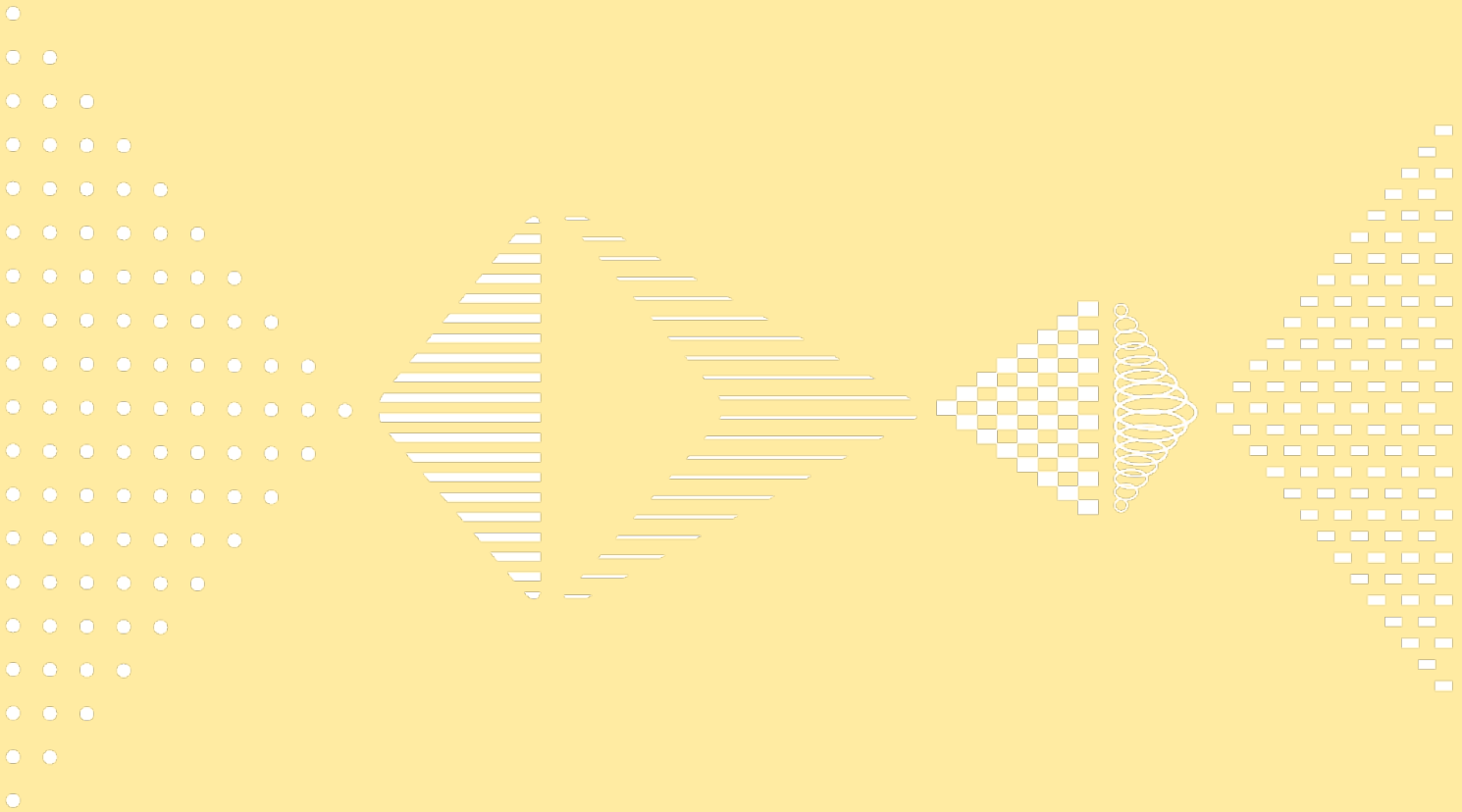
The Parliamentary Ombud's assessments of conditions that pose a risk of torture and inhuman treatment are based on a broad range of sources. During the visits, the national preventive mechanism examines the conditions at the location through observations, interviews and documentation reviews. Private interviews with persons deprived of their liberty is a particularly important source of first-hand information about the conditions. Interviews are also conducted with staff, management and other relevant parties and documentation is obtained to clarify the conditions at the location, such as guidelines, decisions, logs and health documentation.

After each visit, a report is written, describing findings and recommendations for how the facility in question can prevent torture and other cruel, inhuman or degrading treatment or punishment.

[1] Sections 1, 17, 18 and 19 of the Norwegian Parliamentary Ombud Act.
[2] UN Subcommittee on Prevention of Torture (SPT), Prevention Mandate Recommendations, 30 December 2010 CAT/OP/12/6.

The reports are published on the Parliamentary Ombud's website and the facilities visited are given a deadline for informing the Ombud about their follow-up to the recommendations. These letters are also published.

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



II. Summary

Responsibilities of the municipality
In October 2021, the Parliamentary Ombud's National Preventive Mechanism visited adults with developmental disabilities living in the Municipality of Hamar receiving an around the clock service. Five people lived in a group home of varying sizes. One person lived in an independent department. The subjects of the Parliamentary Ombud visit were selected following a review of the Municipality's administrative decisions on the use of force for seventeen people.

In general, the employees and managers of the homes were highly conscious of enabling residents to make choices and impact their own daily lives. It also appeared that the wish of the residents to have a private life, including the possibility to have a sex life, were largely taken into consideration.

The fundamental rights of four of the residents were at high risk due to the planning of the housing service. The Parliamentary Ombud is concerned that the living conditions of the resident innately contributed to isolation, deterioration of existing health problems and invasive use of physical force. It emerged that the use of force could have been avoided if the residents had lived elsewhere or the composition of residents and the living environment had been arranged differently. The municipality's administrative decisions provided little information on whether other housing solutions had been considered and tried. The overall situation in the homes for these residents put them at risk of inhumane and degrading treatment.

Residents in a lot of pain with comprehensive needs for health monitoring had great difficulty in getting essential and correct medical assistance. Aggressive behaviour and serious self-harm resulted in these residents being exposed to extensive coercion. The Parliamentary Ombud is concerned that the municipality does not provide equitable mental health services for people with developmental disabilities. Our experience with the specialist health service was that aggressive and self-harming residents were not adequately taken seriously as potential symptoms of health problems and pain. The behaviour was instead attributed to their developmental disability despite the repeated objections of municipal employees who knew the resident well. This appeared to extend the investigation period, which contributed to maintaining a stressful general situation for the resident, relatives and employees. The municipality did not use individual plans as an instrument to ensure the residents received necessary and coordinated services. When pain and development of illness leads to behaviour that is met with physical coercion, the risk of inhumane and degrading treatment increases. The Parliamentary Ombud therefore considers these findings serious.

The review of the administrative decisions on the use of force showed that the municipality's assessment of the conditions of the law and grounds for the decisions were flawed. For example, administrative decisions had been passed regarding the locking of doors to prevent the resident from leaving the home. Such locking is a form of deprivation of liberty, which is not authorised by the Norwegian Municipal Health and Care Services Act, Chapter 9. It was not transparent how the municipality had assessed that the conditions for the force measure were satisfied. Further, the municipality had not assessed the overall effect of the resident being subjected to multiple force measures. In summary, the findings indicated a need to strengthen the internal quality assurance of the municipality's administrative decisions on the use of force.

There seems to be a distinct need for more professional competence within the service, and more training and guidance in the day-to-day work. This particularly applied to training on general illness development in people with developmental disabilities, and guidance on recognising symptoms of pain and mental health issues. The main impression was that the municipality worked minimally on systematically ensuring regular guidance and follow-up for employees. The municipality experienced a gradual reduction of its habilitation services, and higher expectations that the municipality would provide competence enhancement measures itself.

No information emerged to suspect that employees had been violent towards or sexually abused the residents we visited. At the same time, the findings indicated that the municipality should work more systematically in relation to creating awareness around the fact that people with developmental disabilities are at higher risk of being exposed to violence or abuse in close relationships and from employees.

Responsibilities of the County Governor

All active administrative decisions on the use of force at the time when the Parliamentary Ombud visit was approved by the County Governor, and all applications for dispensation from the education requirement were granted for a large number of people. None of the County Governor's re-examinations were appealed to the County Social Welfare Board, and no formal complaints were made to the County Governor regarding decisions on the use of force in individual acute situations. It appeared that the employees at the homes were not very familiar with the right to complain to the County Governor and appeal to the County Social Board.

The County Governor had not carried out on-site supervision for four of the residents after administrative decisions on the use of force had been passed. Two of the four residents lived in the same group home where multiple risk factors existed indicating that on-site supervision should have been carried out.

The overall impression is that the County Governor's case processing raised questions about whether the municipality's administrative decisions had been properly checked. The flaws in the County Governor's assessments and reasons were significant and contributed to a higher risk of unauthorised, unnecessary and disproportionate use of force. It was not clear how the County Governor had assessed all the conditions of the law for the specific measures. It was particularly serious that the County Governor had approved the municipality's administrative decisions involving illegal deprivation of liberty.

The findings also showed a high demand from the municipality for guidance in individual cases, and that employees and managers at the homes often consulted the County Governor when planning force measures for certain residents. The involvement of the County Governor in specific cases before they were forwarded from the municipality seemed to risk mixing the roles of guide and inspector in an unfavourable way. This impression was reinforced by the County Governor having approved administrative decisions on illegal measures.

Several guardians lacked understanding of their role and considered themselves a financial guardian even though the guardian mandate also included the resident's personal life. Guardians were also reluctant to appeal administrative decisions under the Norwegian Municipal Health and Care Services Act, Chapter 9. Additionally, guardians were barely aware of the possibility to assert on behalf of the resident that their rights under the Norwegian Patients' and Users' Rights Act were inadequately

fulfilled. Thus, they did not satisfy the function attached to the guardian arrangement to provide protection accorded by the law. This indicated the need for more monitoring and adapted training and guidance for guardians.

III. Recommendations

The following recommendations are made on the basis of the NPM's visit:

Recommendations for the municipality

Personal autonomy and force:

- The municipality must ensure that the residents' capacity to give consent and their ability to make choices are adequately emphasised in the assessment on whether the force measure is proportionate and ethically sound.
- The municipality must ensure that oral and written information, including determinations and administrative decisions, is given to relatives in a language they understand.
- The municipality must ensure that individual force measures that are part of an administrative decision on the use of force is weighed up against all the conditions of the law and is clearly stated in the grounds for the decision.
- The municipality must ensure that residents are not prevented from leaving their homes or are locked in unless the conditions for the use of force are satisfied.
- The municipality should strengthen the internal quality assurance of administrative decisions on the use of force.
- The municipality should ensure that all offered housing is planned and adapted in a manner that enables residents to feel safe without any exposure to unnecessary and disproportionate use of force.

Preventing force:

- The municipality should ensure that evaluation meetings are held with residents and employees after using force and difficult incidents.
- The municipality should ensure that the service has the necessary and sufficient amount of competence, and that the services are organised and staffed in a way that does not increase the risk of unnecessary and disproportionate use of force.
- The municipality should provide more guidance for staff in their day-to-day work, systematic measures to compensate for exhaustion in various shift schemes, and provide meeting arenas for the personnel group to facilitate adequate flow of information, a common understanding of goals and routines, and necessary training and guidance.

Health monitoring and equitable health service:

- The municipality should implement measures to enable employees to map the health condition of residents, and recognise signs of pain and disease development.
- The municipality should provide more training and guidance for employees about the mental health of people with developmental disabilities.
- The municipality should ensure that the residents have access to equitable municipal mental heath services.
- The municipality should strengthen the cooperation between the specialist health service to ensure that residents with complex and comprehensive health problems receive the necessary medical assistance.

Protection from violence and abuse:

- The municipality must implement measures to increase employee awareness and knowledge about violence and abuse to enable them to prevent, recognise and handle such incidents.
- The municipality should provide routines for evaluating risks and recording non-conformities when other residents are violent.

Recommendations for the County Governor

Checks and protection accorded by the law:

- The County Governor must ensure the conduction of on-site supervision when an administrative decision on the use of force is approved and otherwise when the nature of force measures and other risk factors indicate supervision.
- The County Governor must ensure that the municipality's administrative decisions are checked, so all use of extensive coercion is only exercised when the associated conditions are satisfied and the legal assessments are clearly stated in the grounds for the decision.
- The County Governor should ensure that responsibility for guidance in the municipality is balanced against consideration towards a real and independent review of the administrative decision on the use of force.
- The County Governor should ensure that guardians receive suitable training and guidance to enable them to wholly safeguard their interests within the boundaries of the guardian mandate.

Office address: Akersgata 8, Oslo
Postal address: P.O. Box 3 Sentrum, NO-0101 Oslo
Telephone: +47 22 82 85 00
Free of charge: +47 800 80 039
Fax: +47 22 82 85 11
Email: postmottak@sivilombudet.no
www.sivilombudet.no

Hamar Municipality. Photo: Sivilombudet.