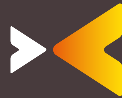

SIVILOMBUDET

Norwegian Parliamentary Ombud

National Preventive Mechanism against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

ANNUAL REPORT 2022

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The National Preventive Mechanism: The Year at a Glance

In 2022, our work to prevent inhuman and degrading treatment covered people living under vastly different circumstances – from the elderly in nursing homes to patients in secure psychiatric units.

During the first months of 2022 we finalised a sequence of visits to nursing homes. This period was still strongly impacted by the pandemic. With high infection rates in the general population, it was a demanding task for the NPM to ensure that our presence did not put the nursing home residents at undue risk. At the same time, we observed that high infection rates led to exceptional staff shortages in the nursing homes. As such, we had to be in close dialogue with the places we intended to visit, to avoid turning up at times when staff absence due to illness was particularly high. Bearing in mind the responsibility to *do no harm,* it was important that our visit did not significantly impair the nursing homes' ability to provide good nursing and care.

As the year progressed, these challenges were reduced, and by summer, our work was barely impacted by the pandemic.

The NPM visits in 2022 covered a wide range of fields. In the first half of the year, we visited three nursing homes in Lørenskog and Oslo municipalities and three housing units for adults with developmental disabilities in Bodø Municipality. These visits marked the end of a two-year investigation into the conditions for adults living with invasive restrictions, whilst under municipal care. Our visits uncovered significant weaknesses in the legal and procedural safeguards of both nursing home residents and adults with developmental disabilities. To highlight this, we compiled key findings from our visits in two summary reports. We hope these summaries will contribute to both increased awareness and concrete improvements in the work of municipalities, as well as regional and national authorities. The findings are described in further detail in a separate thematic article in this annual report.

In order to ensure that our recommendations are followed up by the responsible authorities, we initiated numerous meetings in the autumn with national authorities, such as the Norwegian Directorate of Health, the Norwegian Board of Health Supervision and the Norwegian Civil Affairs Authority. We held lectures for learning disability nurse students, and we arranged open meetings to create awareness and interest in our findings. The initiatives were consistently well-received. We believe that our work in these two areas contribute to both necessary changes in practice, as well as increased knowledge regarding the rights of adults with developmental disabilities and nursing home residents.

Our correspondence with the municipalities that we visited also shows us that many changes already have been implemented in line with our recommendations.

In the autumn, we visited the three largest high security psychiatric units in the country for the first time: Dikemark (outside Oslo), Østmarka (in Trondheim) and Sandviken (in Bergen). These are specialised units that investigate and treat patients with serious mental health conditions and where there is a high risk of violence. The units have a high level of security and severe forms of deprivation of liberty. Our visits focused on a range of issues such as the use of coercion, the use of mechanical restraints, physical interventions, solitary confinement, seclusion and limita-

tions on external communication. Reports on the three visits will be published in 2023. Parallel to this work, we have also contributed to the Parliamentary Ombud's investigation on the use of mechanical restraints in mental health care more generally. In this investigation, we uncovered major weaknesses in the procedural safeguards for patients who are subject to mechanical restraints.

In 2022 we have also noted positive changes due to previous' years' NPM visits. In February, the Director of Public Prosecutions forwarded a new guideline to the prosecution authorities emphasising that decisions to arrest minors shall contain a concrete reason stating why the arrest is 'especially required' and why it is proportionate. This is a clear response to our recommendations after our visit to minors at Oslo Police District Custody Facility in 2021.

In March, the Directorate of Norwegian Correctional Service announced that they are working towards abolishing the use of mechanical restraint beds in Norwegian prisons. This is very positive news and in line with the recommendations in our thematic report from 2020 "The Use of Restraint Beds in Norwegian Prisons". It is crucial that restraint beds now are replaced with better monitoring, more human contact and better access to health care services in Norwegian prisons.

At the same time, we regret to note that the authorities' follow-up of recommendations in our special report on solitary confinement from 2019 is proceeding too slowly. This applies in particular to a pressing need for legislative change, as highlighted in our report. We still find that many prisoners are not offered meaningful activities together with other inmates. Many prisons strive to ensure that inmates are offered an absolute minimum of time out-of-cell, in community with other inmates. Although the Directorate of Norwegian Correctional Service works actively to reduce solitary confinement in Norwegian prisons, this work is jeopardized and at times undermined by a difficult financial situation in the prison sector, unsuitable, old prison buildings and stretched human resources.

Photo: Mona Ødegård

The provision of adequate health services in prisons is also an ongoing challenge, and this year we have received several concerning messages from inmates and staff alike. We are anticipating the publication of new guidelines for prison health care services by the Norwegian Directorate of Health. The provision of health services is also linked to the topic of preventing suicide and self-harm amongst inmates. In the past year we have investigated how the prison authorities in Norway work to prevent such incidents. The investigation shows that both prisons and other stakeholders must work to improve its efforts to prevent suicide and self-harm in prisons.

In 2022 we found it necessary to continue our longstanding dialogue with the Norwegian Ministry of Justice and Public Security regarding the Trandum Police Immigration Detention Centre. We disagree with the Ministry on several points, such as the legality of the extent to which immigration detainees are incarcerated and the practice of confiscating their mobile phones during their stay at the detention centre. These are some of the issues that we will be closely monitoring in the future.

Hanne Harlem
Parliamentary Ombud

Hanne Harlem

Visits in 2022

The core task of the NPM is to visit facilities where people are, or can be, deprived of their liberty. A visit process entails thorough preparations including gathering extensive documentation, conducting physical visits over the course of two to four days, analysing data and gathering further documentation, writing a visit report and then engaging in dialogue with the facility that has been visited. In this section, we provide information about the visits carried out in 2022.

Visit to Stovnerskoghjemmet Nursing Home in Oslo municipality

Visit conducted: March 2022
Report published: June 2022
Status as of December 31st 2022: case closed September 2022

After our visit to Stovnerskoghjemmet Nursing Home, we concluded that the nursing home was working well to prevent coercive measures against the residents. Our impression was that staff had a high level of awareness about what is defined as, and could be perceived as, coercive measures. We also found that there were opportunities for interdisciplinary reflection and dialogue amongst staff regarding ethical dilemmas and the use of coercive measures. The nursing home's decisions to use coercive measures were concrete and individually justified. The decisions also documented that the legal requirements had been fulfilled. In our visit report, we recommended the nursing home to continue its on-going work to avoid routine restrictions on the freedom of movement. We also recommended that the nursing home continue measures to ensure staff competency on the use of coercion in healthcare. The nursing home provided the NPM with a good account on how they are following up our recommendations, and we therefore decided to close the case.

Stovnerskoghjemmet Nursing Home in Oslo.
Photo: The Parliamentary Ombud/NPM

Visit to two nursing homes in Lørenskog municipality

Visit conducted: March 2022
Report published: June 2022
Status as of December 31st 2022: case closed November 2022

In March 2022, the Parliamentary Ombud visited two nursing homes in Lørenskog municipality. Here we found that staff lacked sufficient knowledge about the regulations that govern the use of coercion in the healthcare sector. We also uncovered a lack of oversight on the decisions made to use coercive measures as well as cases where coercive measures had been used without an administrative decision, which is required by law. The municipality also lacked procedures for preventing and handling aggressive behaviour between residents and situations where residents could be subject to abuse by staff.

In October 2022, the municipality informed us of several measures that were introduced, following our report. The key procedures for using coercion in the municipal healthcare system were revised, and the municipality has also made positive changes to its case management system. These changes gave the municipal leadership a better overview of decisions to use coercive measures and a better dialogue with the oversight authorities at the County Governors' office. The municipality has also assessed the use of measures that restrict movement, such as bed guard rails and chair restraints, and is also reviewing its procedures on the use of welfare technology. Work is also undertaken to improve courses and training on the use of coercive measures in the nursing homes, and it appears that more time is allocated for staff discussion and reflection regarding the use of coercive measures. The municipality has also developed new procedures for the prevention and management of violence, and adjusted its internal control systems, to differentiate between injuries caused by other patients and injuries caused by staff. In light of the municipality's account, the Parliamentary Ombud decided to close the case.

Visit to nursing homes in Lørenskog municipality.
Photo: The Parliamentary Ombud/NPM

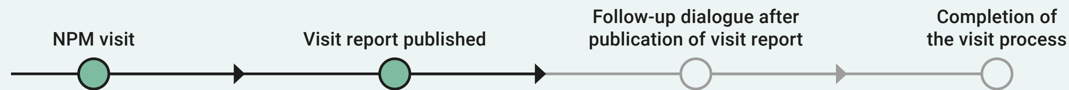
From our visit during the pandemic.
Photo: The Parliamentary Ombud/NPM

"Following the Parliamentary Ombud's visit, the departments have [...] had a much greater focus on documentation and on updating action plans in order to ensure that documentation regarding the use of coercive measures is correct."[1]

1 Letter from Lørenskog municipality to the Parliamentary Ombud, 14 October 2022.

Visits to homes for persons with developmental disabilities in Bodø municipality

Visit conducted: April 2022
Report published: September 2022
Status as of December 31st 2022: awaiting feedback from municipality and the County Governor



In April 2022, the NPM visited six adults with developmental disabilities, in three residential facilities in Bodø municipality. The visits uncovered weaknesses in the quality of the municipality's and supervisory body's (County Governor) decisions to use coercive measures as well as disorganisation and undue delays in the approval of such decisions. As a result, several residents in the municipality were subjected to coercive measures for long periods without a valid administrative decision, some for more than a year. In addition to this, the NPM found that difficult living conditions and staffing problems increased the risk of excessive use of coercion. The risk was particularly high for one resident who was locked in 24 hours a day, a practice which is not permitted by the Norwegian Health and Care Services Act. The NPM is highly critical to the fact that this illegal deprivation of liberty was not identified in the County Governor's legal review of the case. We also uncovered weaknesses in the way in which the municipality assessed and followed up the residents' health conditions. Bodø municipality and the County Governor of Nordland must respond to the findings of the report by 15 January 2023.

Visits to secure psychiatric units at regional level (RSA) at Dikemark, Østmarka and Sandviken.

Secure psychiatric units is the part of the mental health services that assesses and treats patients with serious mental health conditions and where the risk of aggression or severe violence is high. The secure psychiatric units in Norway are are found at both regional and local level. At the regional level, the units accept patients with severe violent behaviour and with a greater need for extra security measures and a higher staffing level than the local level.[2]

In 2022, the NPM visited three out of a total of four secure psychiatric units at the regional level. We visited the three biggest units, which fall under the administration of South-Eastern Norway Regional Health Authority (Oslo University Hospital, Dikemark), Western Norway Regional Health Authority (Bergen Hospital Trust, Sandviken) and Central Norway Regional Health Authority (St. Olavs Hospital, Østmarka). Information about the units is as follows:

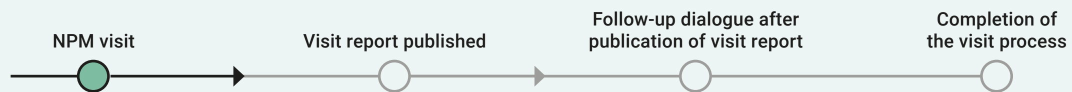
Regional health authority	Health trust	Facility	Number of beds as of August 2022	Number of wards
Southern and Eastern Norway	Oslo University Hospital	Dikemark	22	3
Western Norway	Bergen Hospital Trust	Sandviken	10	2
Central Norway	St. Olavs Hospital	Østmarka	10	2
Northern Norway	University Hospital of North Norway and Nordland Hospital Trust	Tromsø and Bodø	5	The beds are located in local secure units.

2 In the local secure units, the staff-patient ratio must be a minimum of 3 : 1, while in the regional secure units, the ratio must be a minimum of 5 : 1, cf. Report to the Storting no. 25 (1996–1997) p. 100 (Box 4.2). This means that there are, respectively, three or five members of staff per patient in any 24-hour period.

Visit to secure psychiatric section, Oslo University Hospital HF, Dikemark

Visit conducted: August 2022

Status as of December 31st 2022: Report not published

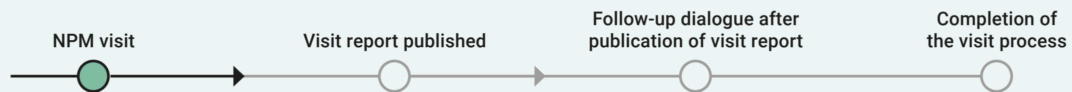


Secure psychiatric unit Dikemark. Photo: The Parliamentary Ombud/NPM.

Visit to secure psychiatric unit, St Olavs Hospital HF, Østmarka

Visit conducted: September 2022

Status as of December 31st 2022: Report not published



Secure psychiatric unit Østmarka. Photo: The Parliamentary Ombud/NPM.

Visits to secure psychiatric ward, Bergen Hospital Trust HF, Sandviken

Visit conducted: December 2022

Status as of December 31st 2022: Report not published

Secure psychiatric unit Sandviken. Photo: The Parliamentary Ombud/NPM.

Follow-up of previous Visits

An important component of the NPM work takes place after the visit reports have been published.

All the places we visit are required to provide written feedback describing how our recommendations are followed up, no later than three months after the visit report has been published. We then consider whether the measures implemented are satisfactory.

All correspondence with the facility is publicly available and continuously published on our website.

In some cases, the follow-up work requires more extensive communication and it will take longer for the NPM to be able to close the case. In 2022, we followed up on five visits from 2020 and 2021. These were cases that had not been closed by the start of 2022.

Care homes for persons with developmental disabilities, Kristiansand municipality / County Governor of Agder

Visit conducted: November 2021
Report published: April 2022
Status as of December 31st 2022: case closed November 2022

The NPM visited seven adults with developmental disabilities who received extensive municipal care in four different homes in Kristiansand municipality in 2021. During the visit, we found that several residents were subjected to unlawful seclusion and incarceration. This represents a risk of inhuman or degrading treatment. The visit also identified that the living conditions contributed to an increased risk of disproportionate use of coercion. We also found inadequacies in administrative decisions on the use of coercive measures, as well as serious weaknesses in the County Governor's (the oversight authority) review of these.

In its response in September 2022, Kristiansand municipality informed us of a series of improvement measures in line with the report's recommendations. The municipality was in the process of implementing an annual internal audit of randomly selected administrative decisions on coercion, to improve the quality of these decisions. The municipality was also going to pilot the use of a dedicated nursing resource with both somatic and mental-health experience, in one of the bigger group homes visited by the NPM. All the residents would also be offered an individual health plan and a coordinator for this, during the autumn of 2022. The municipality was also looking at making adjustments and changes to the accommodation arrangements for several of the residents visited by the NPM. In light of this response, the NPM closed the case with the municipality.

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"During the visit we found that several residents were being subjected to unlawful seclusion and incarceration"

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Some recommendations in our visit from Kristiansand were directed to the oversight body – the County Governor of Agder. They provided their feedback at the end of August. They reported that work had been initiated to ensure that every decision is in accordance with legal requirements, and that the decisions are adequately justified. The County Governor will also update relevant guardianship mandates, to clarify the role of guardians in accordance with Chapter 9 of the Norwegian Municipal Health and Care Services Act. Based on this information, the NPM has closed the case with the County Governor.

Care homes for persons with developmental disabilities, Hamar municipality / County Governor of Innlandet

Visit conducted: October 2021
Report published: April 2022
Status as of December 31st 2022: Case closed with the County Governor in August 2022 – case closed with the municipality in December 2022

In October 2021, the NPM found that unsuitable living conditions and inadequate healthcare resulted in the unnecessary use of force and coercion towards persons with developmental disabilities in Hamar municipality. We met residents who were living with pain and health problems, but who were not given access to necessary healthcare. Untreated health problems cause aggressive behaviour, which in turn, can lead to an increase in the use of coercive measures. The NPM also found several weaknesses in the County Governor's assessments and justifications in decisions to use coercive measures, including the approval of unlawful deprivation of liberty.

In its response of June 2022, Hamar municipality referred largely to existing procedures and working methods. The NPM therefore repeated its request that the municipality provide an account on specifically how they are following up on the recommendations in the visit report. In October 2022, the municipality informed us that they had drawn out a specific action plan which includes training and skills-development for staff, the development of better management systems and measures to improve coordination between the municipal services and the specialist health service. According to the municipality, most of the measures will be implemented in the first six months of 2023. The municipality has also announced that a construction project, which will provide a more suitable accommodation for people with complex needs for services, will be completed in 2024. After this information was provided, the NPM closed the case.

The visit report also included recommendations to the oversight authorities, the County Governor of Innlandet, who responded to us in June 2022. Among other things, the County Governor has introduced procedures to ensure better assessments on whether physical supervision visits should be undertaken. They have also implemented specific measures to improve the quality of their case work, and they will themselves keep an overview of cases where they consider that there is a risk of unlawful use of coercion. As a result, the NPM decided to close the case with the County Governor of Innlandet.

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"As part of the improvement work, we have [...] decided that we will perform an internal audit every year. In this audit, we will select a certain number of random administrative decisions for review, in order to establish whether the decisions are in line with the Parliamentary Ombud's recommendations."[3]

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3 Letter from the County Governor of Innlandet to the Parliamentary Ombud dated 15 June 2022.

Children in police custody, Oslo Police District

Visit conducted: May 2021
Report published: December 2021
Status as of December 31st 2022: case closed August 2022

In May 2021, the NPM visited Oslo Police Custody Facility, where we examined the conditions for minors. When children and young people are arrested and taken into custody, this requires special facilitation and adaptation from the authorities. The NPM found that Oslo Police Custody Facility did not have good alternatives to holding cells, and that the minors did not have continuous access to adults during their stay in police custody. Furthermore, we found that the minors often did not receive enough information about their rights, and that some stays in police custody were unnecessarily long, due to practical barriers, such as the lack of staff to conduct interrogations during the evenings.

From the visit to Oslo Police Custody
Photo: The Parliamentary Ombud/NPM.

The NPM received feedback from Oslo Police District in March 2022. We then requested further information and documentation on the police district's follow-up of our recommendations, and additional information was sent to us in June 2022.

Oslo Police District informed us that they have developed new procedures for handling minors in police custody, and that they have conducted internal training on the use of custody records. The NPM received and reviewed custody records from the first quarter of 2022, and they now contain specific descriptions of the actual conditions and justifications of important decisions during the minors' stay in custody. This is a considerable improvement compared to the records we reviewed a year earlier.

The police district has also taken steps to reduce the time that minors' stay in police custody. Upon request by the police district, Oslo District Court and Ringerike, Asker and Bærum District Court have decided to give the prosecuting authority the power to send for a defence counsel outside the courts' working hours.[4] This change could help to reduce the length of stay in police custody for minors apprehended in the evenings. The NPM closed the case in August 2022.

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"We have seen [...] that internal training and an increased focus on the keeping of custody records has led to more detailed record-keeping."[5]

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4 Letter from Oslo Police District to the Parliamentary Ombud dated 1 March 2022. "Upon request by Oslo Police District, Oslo District Court and Ringerike, Asker and Bærum District Court decided on 27 January this year to give the prosecuting authority the power to send for a defence counsel, pursuant to Section 100 second paragraph of the Norwegian Criminal Procedure Act ('special reasons'), outside the courts' working hours. This is particularly relevant in serious cases, where an interview is conducted on the same evening as the arrest and the minor is not expected to be detained for longer than 12 hours."

5 Letter from Oslo Police District to the Parliamentary Ombud dated 30 June 2022.

Nursing home in Horten municipality (Åsgårdstrand Nursing Home)

Visit conducted: December 2020
Report published: May 2020
Status as of December 31st 2022: case closed May 2021

In 2020, the NPM visited Åsgårdstrand Nursing Home in Horten municipality. Staff at the nursing home displayed a high level of professional and ethical reflection regarding the use of coercive measures, but many appeared to be uncertain about how the rules on the use of coercive measures should be applied in practice. We also found weaknesses in how healthcare was documented.

In autumn 2021, the NPM received feedback from Horten municipality. Other than measures to improve its documentation, the response from the municipality largely referred to existing routines and procedures. In December 2021, the NPM therefore requested more detailed information about how the municipality was following up on our recommendations. We received new information from the municipality in February 2022. Here the municipality told us, among other things, that they were planning an internal audit based on our findings, with a review of decisions to use coercive measures. Issues such as whether the participation of relatives was adequately documented, as well as a review of how activity and nutrition are documented in the records would be discussed. The municipality also informed us that they had tightened up procedures regarding decisions to use coercive measures and introduced a routine involving a daily review of records by a specialist nurse. Overall, the municipality's response gave us the impression that they had implemented several important follow-up measures, and the NPM therefore closed the case in May 2022.

Care homes for people with developmental disabilities, Drammen municipality / County Governor of Oslo og Viken

Visit conducted: November 2020
Report published: June 2021
Status as of December 31st 2022: case closed March 2022

In 2020, the NPM visited three group homes for adults with developmental disabilities in Drammen municipality. A main finding was that the municipality used planned coercive measures towards several residents without an approved administrative decision from the County Governor, as required by law. As a result, the report not only contained recommendations to the municipality, but also to the oversight authorities at the County Governor of Oslo og Viken.

In 2021, the NPM closed its dialogue with Drammen municipality after having received a detailed account of the municipality's follow-up work. The first response from the County Governor, however, was brief. It contained little reflection on its own practice and the findings and recommendations of the NPM. The NPM therefore requested a more detailed account of issues such as the measures to avoid unauthorised use of coercion and adequate training of legal guardians. The County Governor provided more detailed information about this work in February 2022. The case was subsequently closed by the NPM.

Advisory, Educational and Cooperation Function

Outreach work is an important part of our work as National Preventive Mechanism. In 2022, we have lectured for students, participated in reference groups, held meetings with national authorities, participated in governmental consulations and presented our findings at relevant conferences. Below we present some highlights from the past year.

Nursing homes and homes for adults with developmental disabilities

In the autumn of 2022, we undertook several activities to share insights and recommendations from our visits to nursing homes and homes for adults with developmental disabilities to a broader audience. To achieve this, we prepared two summary reports which distilled findings and recommendations from eight different visit reports. The summaries present the overarching challenges that we have observed across the municipalities we have visited, and include general recommendations for municipalities, county governors and national authorities.

In October, we presented our national recommendations to the Standing Committee on Local Government and Public Administration and the Standing

Meeting with the Storting's Standing Committee on Health and Care Services of the Storting.
Photo: The Parliamentary Ombud/NPM.

Advisory Committee

The NPM's Advisory Committee shall contribute with expertise, information, advice and input to the NPM.* In 2022, the Committee held three meetings where topics such as visits to nursing homes and homes for adults with developmental disabilities were discussed. The members have given us valuable information about relevant themes for further exploration, such as "restrictive government funded parole", which is a form of deprivation of liberty which we were not aware of. Committee members have also contributed to spreading knowledge about our work and recommendations.

In 2022, we created a written mandate for the Advisory Committee, emphasising that the members are appointed for two years at a time. The mandate also distinguishes clearly between individual members on the one hand and members who represent selected organisations on the other. The mandate enters into force in 2023.

Members of the advisory committee 2022:

- The Norwegian Bar Association.
- Amnesty International Norway
- Ombudsperson for Children in Norway
- Norwegian Helsinki Committee
- Jussbuss (free legal aid clinic run by students)
- Norwegian Association for Children in Care
- The National Association We Shall Overcome
- The Norwegian Equality and Anti-Discrimination Ombud
- Mental Health Youth
- Norwegian National Human Rights Institution (NIM)
- Norwegian Association for Persons with Intellectual Disabilities (NFU)
- Norwegian Organisation for Asylum Seekers (NOAS)
- Norwegian Psychiatric Association
- Human Rights Committee of the Norwegian Psychological Association
- Norwegian Alliance for Informal Carers
- Norwegian Red Cross
- TvangsForsk (national network for research and knowledge development on the use of coercion in mental health care in Norway)
- WayBack

* Section 19 of the Parliamentary Ombud Act states that "The Parliamentary Ombud shall have a specific advisory committee for his or her work as a national preventive mechanism"

Head of Department, Helga Fastrup Ervik, presenting our work at the SOR-NFU Conference. Photo: Olav Helland.

The Equality and Anti-Discrimination Ombud, Bjørn Erik Thon and the Parliamentary Ombud, Hanne Harlem organized a seminar on the right to health care for people with developmental disabilities. Photo: The Parliamentary Ombud/NPM.

Committee on Health and Care Services at the Norwegian Parliament (Storting). In the same month, we also presented our findings to an audience of 800 people at a conference on the Convention on the Rights of Persons with Disabilities (CRPD), arranged by the Norwegian Association of Persons with Intellectual Disabilities (NFU) and the SOR Foundation.

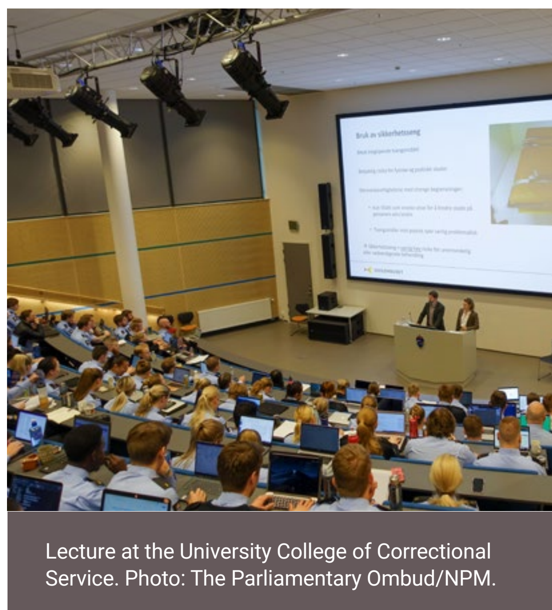
In November and December, we presented our findings to the Board of Health Supervision, the Directorate of Health, the Ministry of Health and Care Services and the Civil Affairs Authority. We also organised a seminar on the right to health care for persons with developmental disabilities. This was done in cooperation with the Equality and Anti-Discrimination Ombud. In addition, we lectured for 150 learning disability nursing students, and child protection and child welfare students at the University of South-Eastern Norway (USN) about our findings from visits to nursing homes, child welfare institutions and homes for adults with developmental disabilities.

Prisons

In 2022, we have shared our findings from previous prison visits and continued working on new prison investigations. We have lectured for bachelor and foundation students at the University College of Correctional Service (KRUS). The Parliamentary Ombud, Hanne Harlem, was also invited to give a presentation at the Correctional Service's management conference in September. We also presented our key findings at the conference Correctional Services Worldwide, which was organised by the Norwegian Directorate of Correctional Service.

In addition to outreach work, the NPM has explored how the correctional services work to prevent suicides and suicide attempts in prisons. We describe findings from this work in a separate thematic article in this annual report. In addition, we have started looking closer at the scheme for "restrictive government funded parole". This is a scheme which entails placement in institutions or municipal housing units with severe restrictions. It is applied to certain prisoners placed under preventive detention.[6] This is a form of deprivation of liberty that the authorities had not informed us of, despite the fact that we have regularly asked them about the number of places where people are deprived of their liberty in Norway. We have now requested and received additional informa-

6 Cf. the Norwegian Criminal Code, Section 45, Subsection 1(c).



Lecture at the University College of Correctional Service. Photo: The Parliamentary Ombud/NPM.

tion about this form of incarceration from the Norwegian Ministry of Justice and Public Security.

Police Custody

In 2021, the NPM investigated the conditions for children in Oslo Police District Custody Facility. The investigation also uncovered broader, national human rights challenges, for example, that the conditions for minors in custody were not adequately documented, children did not receive information adopted to their age, and the authorities did not have a reliable national overview of children in police custody. We have therefore requested clarification from the Norwegian Ministry of Justice and Public Security about what is being done nationally to improve conditions for children in police custody. The Ministry's letter of response provided information about several measures. In February 2022 the Director of Public Prosecutions issued new guidelines stating that all arrest decisions issued by the prosecuting authorities shall clearly state information on why the arrest of a minor is 'especially required' and why it is proportionate. The Ministry also informed us that the National Police Directorate is preparing information material adapted to children in police custody.

Mental Health Care

After publishing 17 reports from visits to mental health institutions, the NPM has continued its dissemination work within this sector. In May, two staff members published an article in the national psychology journal 'Psykologstidsskriftet'. The article looked at the role of psychologists in preventing human rights violations.[7] In addition, we have participated in debates and presented our findings during the annual congress of the Norwegian Psychiatric Association, 'Psykiatriveka'. We have also had good dialogue with SIFER, a national collaboration network of research and education centres focusing on security, prisons and forensic psychiatry. SIFER also provided the NPM with a training workshop, when the unit was preparing its visits to secure pshychiatric units. In the last year, we have also participated in a national reference group concerning the future of secure psychiatric care in Norway.

Child Welfare Institutions

In the past year, the NPM has participated in several meetings regarding child welfare institutions. In March, we held a lecture about our findings from visits to such institutions at an annual seminar for legal practitioners in child law. In April and November, we held a similar lecture at two seminars for child welfare institution managers arranged by the County Governor of Vestfold og Telemark and the County Governor of Agder, respectively. The unit also provided input to the committee for the future of child welfare institutions and held meetings with the Norwegian Ministry of Children and Families.

Police Immigration Detention Centre at Trandum

In 2022, the NPM has expressed grave concern about the conditions for detainees at the Police Immigration Detention Centre at Trandum. We see that our recommendations regarding the centre has not been adequately followed up by the authorities. In 2021 and 2022, we have corresponded extensively with the Norwegian Ministry of Justice and Public Security regarding this issue. We consider that the practice of

7 Refer to *Psykologtidsskriftet* 27 Mai 2022, the Parliamentary Ombud's visit to places where liberty is deprived: https://psykologtidsskriftet.no/fagessay/2022/05/sivilombudets-besok-til-steder-frihetsberovelse.

routinely confining detainees to their cell for parts of the day at Trandum to be illegal and unnecessary. Furthermore, we cannot see that the Norwegian Immigration Act allows for the temporary confiscation of all detainees' mobile phones, which is the current practice at the detention centre. The Ministry has explained their view on the matter and refer to an on-going review whether the responsibility for the immigration detention centre should be transferred from the Police authorities to the Norwegian Correctional Service. The NPM finds it imperative that instant changes are made to ensure that the operations at the immigration detention centre is in accordance with the authorities' human rights obligations.

Following our visits to Trandum in both 2015 and 2017, we pointed out the need to improve the provision of healthcare services to detainees by establishing a scheme that guarantees the full independence of health care providers from the police authorities. Medical services for detainees are currently offered by a private health care provider contracted by the police. In addition, the nurses at the detention centre are directly employed by the police. This is an unusual scheme in a Norwegian context, where the public health service otherwise provides all health services to persons deprived of liberty. The arrangement at Trandum has contributed to uncertainty regarding the professional independence of the health care services for detainees. In the revised National Budget for 2022, the Norwegian Parliament (Storting) requested the Government to ensure that health care services to immigration detainees should be offered by public health services by 1st of July 2023.[8]

Delegation from Tunisia. Photo: The Parliamentary Ombud/NPM.

International Cooperation

As of today, 91 states have ratified the United Nations Optional Protocol against Torture (OPCAT) and there are 77 National Preventive Mechanisms globally.[9] International exchanges and dialogue undoubtedly enhances the quality of our work. Our participation in the Nordic NPM Network, which held one digital and one physical meeting in 2022, has been important for us in the past year. The group has discussed Denmark's outsourcing of prison services to Kosovo, where we could contribute with our experiences from 2015–2018, when Norway rented prison services at the Norgerhaven Prison in The Netherlands. We pointed out that these types of international agreements create legal grey zones, which undermine the prisoner's rights, including protection against torture and inhuman treatment.

In the past year, we have also participated in the 5th Regional meeting for NPMs and Civil Society Organizations (CSO), organized by the Organization for Security and Co-operation in Europe (OSCE) and the Association for the Prevention of Torture (APT). One of the main issues discussed at the meeting was the use of various coercive means and the risk of torture and inhuman treatment in police custody. We have greatly benefited from the dialogue with APT through the year. They have contributed with valuable perspectives to our strategic planning meeting, and we have contributed to their work by, for example, sharing experiences from our work on women in prison.

8 Refer to administrative decision no. 831, 17 June 2022, ref. the Storting's handling of White Paper No. 2 (2021–2022) Revised National Budget 2022.

9 Figures retrieved on 01/11/22: https://www.apt.ch/en/knowledge-hub/opcat-database/list-designated-npm-regions-countries.

Visits to the Municipal Health and Care Services: What did we find?

Between 2020 to 2022, the National Preventive Mechanism visited five nursing homes for the elderly and fifteen homes for persons with developmental disabilities across eight different municipalities. We have investigated the use of coercion against people who rely on 24-hour municipal care services. Below is a summary of our main findings.

Why visit nursing homes and homes for persons with developmental disabilities?
Persons with developmental disabilities can be subjected to invasive restrictions and deprivation of liberty during care. The Norwegian Municipal Health and Care Services Act also allows for the use of coercion as part of the care for persons with developmental disabilities.

Some nursing home residents are also exposed to coercion and severe restrictions. For instance, somatic health care can be given by force to those who refuse such care and at the same time do not have the capability to provide informed consent. As a result, residents can be involuntarily kept in the nursing home and coercion can be used against them in care situations.

In addition, elderly persons with dementia and persons with developmental disabilities may experience a life situation that makes them particularly vulnerable to violations. A high level of dependency on others, combined with inadequate language skills, makes it difficult to alert others of ill-treatment. In addition, insufficient activity, pain and other health problems can cause frustration and aggressive behaviour, which in turn can lead to the use of coercion.

Insufficient protection of legal safeguards
An important finding is that legal and procedural safeguards are insufficiently ensured for residents in nursing homes and people with developmental disabilities who are exposed to coercion. This clearly emerged when we reviewed more than one hundred administrative decisions on the use of coercion. The NPM identified a significant number of decisions on the use of coercion that were not satisfactorily justified. The decisions lacked assessments on whether the coercive measure was professionally and ethically sound, and proportionality assessments were inadequately carried out.

Municipal decisions lack an overall assessment of coercive measures.
According to Chapter 9 of the Norwegian Municipal Health and Care Services Act aimed at people with mental intellectual disabilities, administrative decisions on coercion may encompass many different types of coercive measures. Separately, these measures may be grounded and seem proportional, but in combination they may constitute extremely invasive restrictions that undermine the person's integrity and self-determination. A weakness we uncovered was that many administrative decisions did not contain an *overall* assessment of whether the coercive measures, as a whole, were proportional. We also found that many administrative deci-

sions contained general phrases and did not adequately describe the specific type of coercion that was applied. Such concrete descriptions are particularly important when the personnel group is large and include a considerable number of temporary and unskilled staff. Weak justifications and imprecise administrative decisions may also make it difficult to file a complaint.

The legal and procedural protection of the individual was further challenged by the way the municipalities processed administrative decisions. Deficiencies in the decision-making process led to delays and unclear division of responsibility. For some people with intellectual disabilities, this resulted in long periods where they were exposed to unauthorised coercion by care staff, in some cases lasting more than one year, because a valid administrative decision on the use of coercion did not exist. In several places we found that it was not clear who was designated as responsible for the administrative decisions. As a result, the municipalities had insufficient control of the total use of coercion under their authority.

Role of the County Governors

Effective monitoring and supervision schemes safeguard the protection of persons subjected to coercive measures and can prevent inhuman or degrading treatment. Pursuant to the Norwegian Municipal Health and Care Services Act, county governors shall monitor coercive measures against persons with developmental disabilities. Our visits, which covered four different county governors, uncovered significant deficiencies in such monitoring work.

Several of the county governors' decisions were superficial and contained standard formulations. They also lacked in-depth assessments on ethics and proportionality. The decisions often provided scarce information on how the county governor had specifically assessed the proposed coercive measures in line with the requirements of the Act. The duty to provide clear grounds shall ensure the thoroughness and precision of decision makers and provides an important guarantee of due process for the individual.

Another serious finding was that the county governors had not, in their oversight work, assessed the strict provisions on seclusion provided in Section 9-6, Subsection 2 of the Act. As a result, illegal practices of seclusion and deprivation of liberty was approved. The municipalities and county governors need to be fully aware of the strict conditions for seclusion and deprivation of liberty for persons with developmental disabilities.

Weaknesses in the Guardianship Scheme

The guardianship scheme is an important legal safeguard for people who do not have the competence to give consent on their own. All the persons we visited in nursing homes and homes for persons with developmental disabilities had an appointed guardian. Some of the guardians were relatives and others so-called professional guardians. We spoke to many guardians who had little or no knowledge of the regulations on coercion nor of their particular role when administrative decisions on the use of coercion were passed. Several were not aware that guardians could complain about administrative decisions on the use of coercion, and some had chosen not to receive information about such decisions. Many stated that they had received little or no training on this aspect of being a guardian. This is serious and clearly demonstrates the need for further training and clarifying guardians' responsibility when individuals with guardians are subject to coercion.

Staff lacked knowledge of relevant legislation

During the visits to the the municipalities, we spoke to a total of 168 employees in nursing homes and homes for persons with developmental disabilities. These included both skilled and unskilled, full-time and part-time staff, as well as medical professionals and managers. A consistent finding was that the employees lacked knowledge of relevant legislation and the conditions for using coercion.

Photo: Colourbox.

If the use of coercion is necessary to give a resident of a nursing home essential medical care, an administrative decision must be passed in accordance with Chapter 4A of the Norwegian Patient and User Rights Act.[10] The same applies if it is necessary to prevent a resident from going out to protect their own safety. The use of coercion shall always be documented and grounded in an administrative decision. Many of the employees we spoke to at the nursing homes were not sure when an administrative decision was necessary, even though they worked in departments where many of the patients had dementia. For example, several employees thought an administrative decision was not required if coercion was only used for a short period or in some situations. Some also incorrectly believed that it was the county governor, not the municipality, that validated administrative decisions.

In homes for persons with developmental disabilities, we found that the employees were equally unsure of the regulations governing coercion. Here we visited residents who had complex administrative decisions on the use of coercion in accordance with Chapter 9 of the Norwegian Health and Care Services Act. We therefore expected that competence on the conditions governing the use of coercion in the homes was good. However, many of the employees were unsure of the conditions governing the use of coercion and the requirements for documentation of the grounds. Several pointed out that they needed more training on the topic.

10 The Act also emphasises that trust-creating measures must be tried, the medical care must be considered necessary and the measures must be proportional to the need for medical care.

Illegal Retention of Patients in Nursing Homes

Nursing home residents have the right to freedom. If residents are to be restricted from leaving the premises of the nursing home, it must be based on the conditions of Chapter 4A of the Norwegian Patient and User Rights Act and documented in an administrative decision.

In the nursing homes that we visited, we found that all the residents in reinforced seclusion wards were restricted from leaving the premises by obstacles such as locked doors, complicated door codes and hidden door openers. Many of the patients in these departments had dementia or other cognitive challenges, in addition to other health problems. At the same time, we found that an administrative decision on retention had not been passed for several residents in these departments. In practice they were exposed to severe restrictions to their freedom of movement, without an individual assessment. This is not acceptable and a result of insufficient knowledge about the rules for retaining residents in nursing homes.

Illegal incarceration of Persons with Developmental Disabilities

In all the four municipalities where we visited homes for persons with developmental disabilities, we found instances of residents *routinely* being locked inside their own home. It is only permitted to lock someone in their own home in acute emergency situations. Knowledge of the conditions for locking up a person was generally poor. We also found that residents in several municipalities were separated from other residents and common areas without an administrative decision being passed for this. In some cases, this practice was part of the resident's 'house rules' and was described as a 'normal routine' or 'alternative to coercion'. Knowledge of the fact that seclusion can only be used in emergencies was poor in several municipalities.

During a visit: door stickers with the clear message "let the door stay locked".
Photo: The Parliamentary Ombud/NPM.

Special Risk Factors for Persons with Developmental Disabilities

Living Conditions that increase the risk of coercion

Living conditions may inherently increase the risk of coercion, seclusion and isolation. We visited several shared homes where people with very different and complex needs were placed together, and where violence and conflict between the residents was a major problem. We visited two residents who were placed next door to each other despite a high level of conflict. Both had a low levels of social functioning, required a great deal of care, and were subject to administratively approved coercion from care staff due to challenging behaviour. In order to protect the two residents from each other and avoid escalation and violence, extensive coercion was used.

The physical environment also has a significant impact on the risk of coercion. We met several people who had spent most of their lives in buildings that were poorly adapted for their needs, and where the design of the building, with narrow door openings and unsuitable common areas, could increase the risk of self-harm and ensuing use of coercion.

Weaknesses in the health services for persons with developmental disabilities

Our visits uncovered considerable differences in the health provision for people with developmental disabilities who are entitled to somatic and mental health care on the same terms as others.[11] Painful conditions and illnesses that are not detected and monitored can be expressed through self-harm and aggression. This increases the risk that expressions of pain are met with coercion. Therefore, adequate health care and health monitoring is also important to prevent the use of coercion. This particularly applies to persons with a disability that prevents them from understanding why the pain occurs or is unable to convey information about the pain to their surroundings.

We found that the coordination of health monitoring was often poor, particularly when the resident had complex health issues which required collaboration between various parties, such as housing staff, GPs, habilitation services and other specialist health services. Practically none of the people we met had an individual care plan, even though they were entitled to one under the Norwegian Patient and User Rights Act, Section 2-5.21.

We also uncovered many practical barriers limiting residents' right to adequate health care. This could pertain to difficulties in organising physical check-ups and examinations for residents with severe disabilities. We found that annual health check-ups often were postponed, and residents would go for months and sometimes years without meeting their GP physically. Adequate pain assessment systems for employees in the homes were lacking, which made the communication between the home and the health service complicated. We also met several employees in the homes, who stated that it was difficult to get acceptance for the residents' need for medical care.

More in-depth information is also available in two different summary reports based on our visits to nursing homes and homes for persons with developmental disabilities. The reports are in Norwegian only: https://www.sivilombudet.no/aktuelt/tortur-forebygging/funn-fra-besok-til-boliger-og-sykehjem/

11 Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12 of the Convention on the Rights of Persons with Disabilities (CRPD), and the Norwegian Patient and User Rights Act, Sections 2-1a and 2-1b (refer to the Regulations on Priority Setting in the Health Care Services, Section 2).

Suicide and Suicide Attempts in Norwegian Prisons

The risk of suicide is unequivocally higher for prisoners than the population at large. Mental illness and a lack of human contact are contributory factors. In 2022 the NPM investigated the authorities' effort to prevent suicide among prisoners.

Background

The right to life and obligation to prevent suicide

The European Court of Human Rights (ECHR) has in multiple cases established that the right to life under Article 2 of the European Convention on Human Rights places a positive obligation upon authorities to prevent suicide and investigate deaths that occur in prison.[12] In its case law, the ECHR emphasises that that "the vulnerability of mentally ill persons calls for special protection".[13] The obligation to prevent suicide is also outlined in the European Prison Rules and the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules).

Increased Risk of Suicide

It is well-documented that inmates have higher rates of mental health challenges and that they have a higher percentage of substance-related disorders, than the population at large.[14] These conditions are associated with an increased risk of suicide. In addition, institutional conditions in prisons, such as high security, lack of social contact and solitary confinement contribute to an increased risk of suicide.[15] The Norwegian Government's National Plan for Suicide Prevention 2020–2025 has a chapter exclusively addressing suicide in prison.

The NPM has since its establishment visited 20 prisons. The visits uncovered clear deficiencies in the prisons' suicide prevention work. More than half of the prisons we visited received recommendations from the NPM to strengthen its efforts to prevent suicide. In 2018, the Directorate of Norwegian Correctional Service (KDI) created a new guideline for the prevention and management of self-harm, attempted suicide and suicide in prison.[16] The guideline gives instruction on how prisons shall ensure that such serious incidences can be prevented and potentially followed up later.

With these findings, and the Directorate of Norwegian Correctional Service's guideline as a backdrop, we investigated how the prisons work on preventing suicide and how the authorities ensure independent follow-up and investigation after a suicide has taken place. Our investigation is based on information from 34 high-security prisons, the Directorate of Norwegian Correctional Service and the Board of Health Supervision.[17]

12 ECHR 16 October 2008, Renolde v. France, Application No. 5608/05, Paragraph 85; ECHR, 17 October 2013, *Keller v. Russia*, Application No. 26824/04, paragraphs 92–95.

13 ECHR 16 October 2008, Renolde v. France, Application No. 5608/05, paragraph 84.

14 Victoria Cramer, Forekomst av psykiske lidelser hos domfelte i norske fengsler, Oslo universitetssykehus, 2014.

15 Ad Kerkhof and Erik Blaauw, Suicide in prisons and remand centers: Screening and prevention in Danuta Wasserman and Camilla Wasserman (Ed.), The Oxford Textbook on suicide (First edition), Oxford University Press, 2009; Paolo Roma et al., Incremental conditions of isolation as a predictor of suicide in prisoners, Forensic Science International, 2013 Dec, 233(1-3):e1-2.

16 The Directorate of Norwegian Correctional Service, Guidelines on Prevention and Management of Self-Harm, Attempted Suicide and Suicide in Prison.

17 The investigation was primarily aimed at the Norwegian Correctional Service's work in this field, as such documentation was not gathered from the health care services.

An important limitation in our study is that we have not looked closely at the way the health authorities' have worked with preventing suicide among inmates. In Norway, many prison services are delivered by local and municipal service providers through the "import model". This also applies to the health services, which is provided by the public health authorities. As a result, the health services retains independence from the prison authorities. Medical staff undoubtedly plays an important role in suicide prevention efforts. At the same time, it is important to acknowledge that the prison authorities also play a crucial role in this work, as it controls the inmates' living conditions and has the most extensive day-to-day contact with the prisoners.

Scope of Suicide and Suicide Attempts

There were 25 suicides in high-security prisons from 1 January 2018 up until 31st December 2022. The NPM reviewed 20 of these. Despite a marked increase in the number of suicides in 2021, it is difficult to say anything certain about the causes of the variations. At the same time, it cannot be ruled out that the extensive and restrictive measures implemented in prisons during the pandemic in 2020 and 2021 may have impacted the number of suicides in 2021.

Suicide attempts are a clear indicator of suicide risk.[18] A good overview of the number of suicide attempts will therefore be important in the work on suicide prevention. For this reason, the NPM also obtained figures from the prisons and the Directorate of Norwegian Correctional Service for suicide attempts per prison. The Directorate reported 287 reported suicide attempts in prisons from January 1st 2018 to December 31st 2022.

In more than half of the prisons, we found deviation between the figures for suicide attempts reported by the prisons and the figures reported by the Directorate of Norwegian Correctional Service. For example, one prison reported that they had 43 suicide attempts in the period 2018 to 2021, whilst the Directorate of Norwegian Correctional Service reported 16 for the same prison during this period. According to the Directorate's list, another prison did not have any suicide attempts during this period, but the prison informed the NPM directly that there had been 15 suicide attempts.

In some cases, there might be some uncertainty as to what constitutes a suicide attempt and what is an act of self-harm, with no intention of death. Several of the prisons referred to the fact that the figures on suicide attempts were uncertain and that they therefore could not provide the NPM with these statistics. At the same time, it is unclear why the Directorate of Norwegian Correction Service in many cases provided a different number of suicide attempts in each individual prison than the number provided by the prison directly to the NPM. This discrepancy shows that there is a need to establish a shared understanding of such serious incidents and how they should be reported across the Norwegian Correctional Services.

	2018	2019	2020	2021	2022	Total
Suicides	2	6	2	11	4	**25**
Suicide attempts	44	45	46	57	45	**287**

18 Shaoling Zhong m.fl. Risk factors for suicide in prisons: a systematic review and meta-analysis, Lancet Public Health, 2020; 6:e164-74

A cell in a prison security unit. Photo: The Parliamentary Ombud/NPM.

Investigation finding 1: The Obligation to Prevent Suicide

The European Court of Human Rights has in many cases established that the State is obliged to provide suitable health monitoring of prisoners with an identified suicide risk, as a suicide prevention measure. Breach of this obligation to prevent suicide constitutes breach of Article 2 on the right to life. The Court also established that Article 3, which prohibits torture or inhuman or degrading treatment, was violated in a case where a mentally ill prisoner committed suicide without receiving sufficient medical monitoring.[19]

There are many measures that should be put into place when working to prevent suicides in prisons. Both the European Council's Committee on the Prevention of Torture (CPT) and the World Health Organisation (WHO) have pointed out measures, such as early assessment of a prisoner's condition, adequate training of employees and good flow of information between agencies such as the health service and prison employees, as important components of this work.[20] These measures are also proven to be effective in several academic studies.[21]

The European Prison Rules state that the prison's medical service shall provide for the psychiatric

19 ECHR, 3 April 2001, *Keenan v. United Kingdom*, Application No. 27229/95, Paragraphs 109–116.

20 The European Committee on the Prevention of Torture (CPT), Health care services in prison, Extract from the Committee's 3rd General Report 1993, CPT/inf(93)12-part, paragraphs 57–59; The World Health Organisation (WHO) Preventing suicide in jails and prisons, 2007.

21 Lindsay Hayes, Suicide prevention on correctional facilities: An overview in Michael Puisis, Clinical Practice in Correctional Medicine (Second Edition), Mosby-Elsevier, 2006.; Eric Blaauw et al., Demographic, criminal, and psychiatric factors related to inmate suicide i Suicide and Life-Threatening Behavior, 2005 Feb, 35(1):63–75.

treatment to all prisoners in need of such treatment and pay special attention to suicide prevention (rule 47.2). The Mandela Rules emphasise that the health care services shall provide for the psychiatric treatment of all prisoners in need of such treatment (rule 109).

According to the Directorate of Norwegian Correctional Service guidelines, the risk of self-harm and suicide shall be systematically mapped.[22] This shall take place immediately or shortly after imprisonment. Thereafter, the risk shall be continuously assessed. A prevention plan must be established 'if there are any indications or information that give grounds for concern'. The guidelines point out that potential action points in such a plan could be monitoring performed by employees in the form of conversations and activities, collaboration with the health care services and increased contact with family and friends.

Our investigation showed that there is a clear need to reinforce the work on suicide prevention in prisons. We are particularly concerned about the following three issues:

› **Lacking suicide risk assessments**
  We found that 7 out of the 20 inmates who committed suicide had not been assessed for suicide risk by the prison. For many of the cases we looked into, we found that risk assessments had not been made upon entry to the prison nor later on, despite this being a clear obligation in the guidelines from the national prison authorities.

  In some of the cases we looked into, we found that the prison had not undertaken its own assessments because the inmate was closely monitored by health professionals or had arrived to the prison from a hospital. In other cases, we found that the assessment had not taken place because the prisoner arrived from another prison. In one case we found that assessment was not conducted because the prisoner refused to participate in the screening upon arrival.

  We also found some cases where the inmate had experienced a life crisis or potentially traumatic changes shortly before the suicide took place. This could be the death of a near family member or the transfer from a low-security to a high-security prison. We found no evidence that the prison authorities had made suicide risk assessments in the wake of such life-changing events.

› **Lack of prevention plans when suicide risk is known**
  We also looked closer at the prevention plans that are supposed to be created when a risk of suicide has been identified. Of the 20 inmates that committed suicide and were part of our study, we found that such plans were not implemented for 15. Several of these 15 inmates had been screened upon arrival and had been identified with a heightened risk of suicide.

  We also found significant deficiencies in the content of the prevention plans that existed. They contained very brief descriptions, and largely seemed to log contact with the prisoner, for example, "conversation with an officer', "observation once an hour". It was unclear whether the measures described were carried out once or more regularly over time.

  We found few references to increased activity or human contact in the plans, and only one reference to increased contact with family and networks, despite research demonstrating that such prevention measures are effective. The prisons' prevention plans should include both immediate and long-term measures that are evidence-based, individually customed and evaluated and adjusted over time.

22 The Directorate of Norwegian Correctional Service, Guidelines on Prevention and Management of Self-Harm, Attempted Suicide and Suicide in Prison.

Our review of prevention plans leaves the NPM with an impression that the prisons' prevention measures are lacking and often solely focused on handling immediate risk. Such plans should also include medium and long-term prevention measures that are justified, individually tailored as well as assessed and adjusted over time.

› **Alarming use of solitary confinement and exclusion from the community as a prevention measure**

When preventing suicide, supportive human contact is key.[23] It has been thoroughly documented that solitary confinement can damage health.[24] The ECHR has pointed out that the State must exercise caution when applying solitary confinement if there is a suicide risk.[25] The CPT has also underlined that it is unacceptable to isolate prisoners who are at risk of self-harm and suicide, and that people in such a situation should be transferred to a health care institution.[26] The application of solitary confinement or use of security cells for prisoners, who try to kill themselves, may also breach Article 3 which prohibits torture and inhuman and degrading treatment

In the NPMs Report to the Norwegian Parliament (Storting) about Solitary Confinement and Lack of Human Contact in Norwegian Prisons (2019), we criticised the extensive use of security cells and solitary confinement for prisoners who were at risk of suicide. We also criticized the lack of reliable figures for suicide attempts in prisons. The special report contained several recommendations to reduce the use of isolation and to strengthen health services in prison.[27]

The Directorate of Norwegian Correctional Service's guidelines however, present exclusion from the prison community and security cells as measures to prevent suicide. Even though it states that these shall be short-term measures to prevent imminent risk, it is extremely problematic that social deprivation is emphasised as an instrument of suicide prevention. In addition to the fact that it may increase the risk of suicide in the longer term, this also creates a situation where prisoners may not share suicidal thoughts in order to avoid solitary confinement. This, in turn, reduces the prison's ability to detect suicidal inmates.

Investigation finding 2: The obligation to investigate, monitor and inspect after suicide

All deaths in prisons must be investigated and the ECHR has defined principles on how the investigation should be carried out.[28] A rapidly implemented, efficient and independent investigation is required.[29] The authorities are responsible for securing evidence to establish the cause of death and liability.[30] Depending on the circumstances in each case, the next of kin must also be involved to safeguard their interests.[31]

23 Ad Kerkhof and Erik Blaauw, 2009; The World Health Organisation (WHO), 2007.
24 Sharon Shalev, A Sourcebook on Solitary Confinement. London: Mannheim Centre for Criminology, London School of Economics, 2008.; Peter Scharff Smith The effects of solitary confinement on prison inmates: A brief history and review of the literature. Crime and Justice, 2006:34, 441–528; Flora Fitzalan Howard Howard, The effect of segregation. Prison Service Journal, 2018:236, 4–11.
25 ECHR, 16 October 2008, *Renolde v. France*, Application No. 5608/05, Paragraph 107–109.
26 The European Committee for the Prevention of Torture (CPT). Report for the United Kindergarten following the visit on 30 March to 12 April 2016, 2017. CPT/Inf/(2017)9.
27 Parliamentary Ombud: Special Report to the Norwegian Parliament (*Storting*) on Solitary Confinement and Lack of Human Contact in Norwegian Prisons, Document 4:3 (2018/2019).
28 ECHR, 14 March 2002, *Edwards v. United Kingdom,* Application No. 46477/99, Paragraphs 69–73.
29 ECHR, 17 October, *Keller v. Russia*, Application No. 26824/04, Paragraphs 92 and 95; Article 12 of the United Nations Convention against Torture and other Cruel Inhuman or Degrading Treatment or Punishment (UNCAT) requires investigations wherever there is reasonable ground to believe that anyone has been exposed to torture or other cruel inhuman or degrading treatment; ECHR, Judgment of 16 February 2012, *Eremiášová and Pechová v. The Czech Republic*, Application No. 23944/04, Paragraphs 135–139.
30 ECHR, 18 December 2008, *Kats v. Ukraine, Application No.* 29971/04, Paragraphs 115-116, ECHR, 14 March 2002, *Edwards v. United Kingdom,* Application No. 46477/99, Paragraph 87.
31 ECHR, 17 October 2013, *Keller v. Russia*, Application No. 26824/04, Paragraphs 94-14, ECHR, 2002 March 2002, *Edwards v. United Kingdom,* Application No. 46477/99.

Prison yard at Åna prison. Photo: The Parliamentary Ombud/NPM.

According to the Directorate of Norwegian Correctional Service's guidelines, it is mandatory for prisons to call a doctor immediately when a prisoner dies.[32] The doctor shall confirm the death and issue a death certificate. In addition to the police, the prison head, regional head of the Correctional Services and the Directorate of Norwegian Correctional Service must always be immediately notified about a death. The guidelines for handling deaths in prison do not contain any information about the duty to notify other external authorities, such as prison supervisory boards or the Norwegian Board of Health Supervision. Norway does not have any statutory rules on how prisons shall follow-up suicides committed in prison.

Our investigation revealed serious deficiencies related to subsequent monitoring and scrutiny in the wake of a suicide in prison.

The supervisory boards for the Norwegian Correctional Service, which are appointed by the Ministry of Justice and Public Security, are the prison supervisory bodies. Nonetheless, neither the Directorate of Norwegian Correctional Service's guidelines nor the Directorate's Circular No. 5/2016, mention the the supervisory boards' role in the event of suicide or suicide attempts. Furthermore, none of the local prisons routines for handling suicides and suicide attempts that we looked at, mentioned the supervisory boards. The prison supervisory body does not seem to become involved when serious incidents, such as suicide attempts and suicides occur.

32 The Norwegian Correctional Service, Guidelines to the Norwegian Execution of Sentences Act, General Guidelines: Death, October 2008.

The Board of Health Supervision is an independent supervisory authority for health care services. All authorities offering health and care services, including prison health care services, are obliged to notify the Board of Health Supervision about serious incidents, such as death or extremely severe harm to a patient or user caused by the service. After receiving a notification, the Board of Health Supervision shall assess whether a local inspection will be carried out. Although many of the prisoners who committed suicide were under treatment or in close contact with the health services, we found that only four incidents in 2020 and 2021 had been reported to the Board of Health Supervision. In the same period, 13 suicides and 103 suicide attempts in prison were registered by the Correctional Service. As such, It appears that the Board of Health Supervision is on the whole, not notified of suicides or suicide attempts in prison.

Summary and Recommendations

Overall, our study uncovered clear deficiencies in how the authorities prevent suicides in Norwegain prisons, as well as in the monitoring and scrutiny after a suicide has taken place. The deficiencies identified shows that there is a definite risk that the authorities do not fulfill their obligation to safeguard the prisoners' right to life, and freedom from inhuman and degrading treatment.

The NPM recommends that the following measures are implemented:

- **ensure reliable statistics on suicide and suicide-attempts in prisons**
- **ensure systematic, uniform and professionally sound suicide risk assessments for prisoners, both upon arrival and during imprisonment**
- **reinforce and systematise the prisons' suicide prevention measures by giving prisons the most efficient and scientifically verified working methods possible**
- **ensure that solitary confinement is not used as a tool to prevent or manage suicide risk**
- **ensure that suicides in prison are always investigated, and subject to independent monitoring and scrutiny of both the correctional authorities and health authorities**

National Preventive Mechanism – our work in numbers

Key figures related to the visits

Total completed

9

NPM visits in 2022

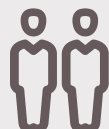
3 visits to homes for adults with developmental disabilities

3 visits to nursing homes

3 visits to secure psychiatric units

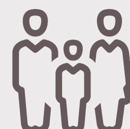
730

individual administrative decisions were reviewed



126

interviews with employees



34

interviews with relatives of persons deprived of liberty

Outreach activities

lectures and talks for various government bodies in Norway

lectures and talks for other national stakeholders

lectures for approx. 1,000 students

Meetings with international stakeholders

The Norwegian NPM unit. From the left: Aurora Lindeland Geelmuyden, Johannes Flisnes Nilsen, Tonje Østvold Byhre, Parliamentary Ombud Hanne Harlem, Head of the NPM Helga Fastrup Ervik, Jakob Mykland Revheim, Mette Jansen Wannerstedt and Karin Afeef. Not in the picture: Pia Kristin Lande. Photo: Mona Ødegård.

NPM visits **2014–2022**

20 Prisons

06 Police custody

22 Mental healthcare

05 Police immigrant detention centres and premises used by customs

22 Child welfare

02 Nursing homes

12 Housing for persons with developmental disabilities

Sectors covered by the NPM's mandate

PRISONS AND TRANSITIONAL HOUSING

DETENTION PREMISES USED BY THE CUSTOMS SERVICE

POLICE CUSTODY FACILITIES, INCLUDING WAITING CELLS

POLICE IMMIGRATION DETENTION CENTRES

CUSTODY FACILITIES OF THE NORWEGIAN ARMED FORCES

INVOLUNTARY INSTITU-TIONAL TREATMENT CENTRE (ØSTMARKA)

MENTAL HEALTHCARE INSTITUTIONS

INSTITUTIONS FOR INVOLUNTARY TREATMENT OF PERSONS WITH SUBSTANCE ABUSE ADDICTIONS

RESTRICTIVE GOVERNMENT FUNDED PAROLE

CARE HOMES FOR ELDRELY

CHILD WELFARE INSTITUTIONS

HOUSING FOR PERSONS WITH INTELLECTUAL DISABILITIES

The number of places where persons with intellectual disabilities can be deprived of their liberty is uncertain. This is due to a variety of reasons, including that many persons with intellectual disabilities live in their own home or in shared housing facilities.

The figures are estimates based on a mapping conducted in 2014/2015, and updated in 2022.

Budget and Accounts for the National Preventive Mechanism 2022

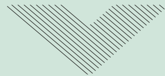
Category	Budget 2022	Accounts 2022
Salaries	**8 740 000**	**8 999 000**
Operating expenses		
Production and printing of visit reports, annual report and information material	150 000	215 081
Purchase of external services (including translation and interpreting services)	650 000	295 229
Travel (visits and meetings)	490 000	311 784
Other operating expenses	495 000	350 643
Share of the Parliamentary Ombudsman's joint expenses (incl. rent, electricity, IT services, security, cleaning etc.)	2 100 000	2 337 584
Total NOK	**12 625 000**	**12 509 321**

Photo: Scott Graham, Unsplash.

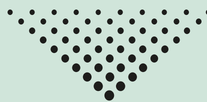
How a NPM visit is carried out

Prepare for the visit and gather information

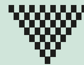
Conduct the visit



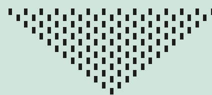
Write a report



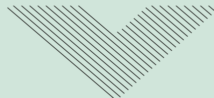
Publish the report wtih findings and recommendations



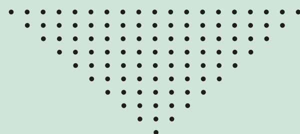
The place of detention follows up the recommendations in the report



The place of detention gives feedback to the NPM regarding the follow-up of findings and recommendations



The NPM makes an assessment of the feedback from the place of detention. Renewed dialogue if necessary



Closing the case

Eco-lighthouse®

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