SIVILOMBUDET
Norwegian Parliamentary Ombud

VISIT REPORT | nr. 69

SUMMARY AND RECOMMENDATIONS

Oslo University Hospital, Regional secure psychiatric ward, Dikemark

30 August – 1 September 2022

National Preventive Mechanism against
Torture and Ill-Treatment

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I. Summary

About the visit and RSA Dikemark

The Parliamentary Ombud's National Preventive Mechanism (NPM) carried out a visit to Oslo University Hospital, regional secure psychiatric ward (RSA Dikemark), from 30th of August to 1st of September 2022. The hospital had been notified that the Parliamentary Ombud planned to carry out a visit sometime in 2022, but was not informed of the exact date of the visit.

RSA Dikemark is in Asker municipality. The hospital complex is made up of several buildings from the 1920s, and is placed in the forest, near recreational areas and hiking trails. Several of the buildings in the complex had not been maintained and were empty.

RSA Dikemark is based in the Granli Building at the edge of the complex, a three-story brick with perimeter security. It is well known that the building is run-down and unsuitable for its current purpose. A new regional secure psychiatric ward will be built at Ila in Bærum municipality and is scheduled to open in 2025.

Our visit included all three of the inpatient units which are in the Granli Building and which make up RSA Dikemark. Each of the three inpatient units was on a separate floor.

Undignified physical conditions contributed to the use of coercive measures

The ventilation system and radiators were not working properly. We were told that it was difficult to maintain a normal temperature at any time of the year, and to allow fresh air in. We also noticed a poor indoor climate, insufficient natural light in parts of the buildings and very difficult acoustic conditions during the visit.

There were visible cracks in ceilings and walls, peeling paint and run-down interior fittings. Overall, the buildings were so poorly maintained that cables, pipes and bricks could be loosened and prised out, and in the worst case used by patients to harm themselves or others. The building's interior fittings, such as door handles, radiators and bathroom fittings had not been designed to reduce the risk of suicide. The many risks tied to these unsuitable physical conditions meant that patients were subjected to more control measures and limitations than necessary. For instance, staff had to observe patients closely and continuously when suicide risk was identified, and in some situations patients were searched *before* being admitted outside, to prevent them from taking dangerous objects with them. Poor lines of sight within the inpatient units increased the risk of dangerous situations. Cramped and visually restrictive stairwells represented a similarly increased risk.

Many patient rooms had no bathroom or toilet, and this helped to create undignified and unsafe situations, for example for patients who were kept secluded in separate rooms, some of whom were restrained by transport restraint systems.

Rooms with restraint beds were placed in a location where it was possible for other patients to see into them. The poor acoustic conditions combined with the location of the rooms with restraint beds, with doors opening directly into common areas, created undignified and unsafe conditions for

patients. The location of the rooms with restraint beds also created a risk that the threshold for the use of mechanical restraints would be lowered and this situation normalised.

On the whole, the NPM found that the very poor physical conditions contributed to increased use of coercive measures and appeared to be undignified for both patients and staff. As many of the patients are admitted to RSA Dikemark for long periods, some for many years, the conditions are particularly censurable, and represent a clear risk that patients are subjected to inhuman and degrading treatment.

Long-term and extensive use of coercive measures

The staff team generally appeared to have a good knowledge of each patient and wished to use coercive measures as little as possible. They described good interdisciplinary cooperation and a culture of asking questions, disagreeing and discussing various problems openly.

The staff appeared to be knowledgeable about the Mental Health Care Act which governs the use of coercive measures, although some staff lacked knowledge about the regulations on the use of isolation. We found that most of the decisions to use coercive measures that we reviewed, provided detailed and specific justifications for the use of coercive measures for the particular patient.

At the same time, we also found major deficiencies in the documentation of *ongoing* assessments on the use of mechanical restraints and whether such restraints continued to be absolutely necessary. This was particularly problematic because in some cases, the use of mobile restraints (mechanical restraints allowing some mobility, for example for walking with short steps or moving one arm) could last for consecutive hours, days, weeks and months.

We also found several cases where individual patients had been subjected to mechanical restraint and seclusion for several consecutive months, with the situation appearing to be at a deadlock. Staff members told us it was particularly difficult to handle situations where members of the staff team had been subjected to serious violence by individual patients, with where the next violent attack was hard to predict. In many cases, staff did not make attempts to go outside to provide patients with an opportunity for movement and activity, due to safety concerns. Patients described empty days with no content, and a lack of control over day-to-day matters. Being able to engage in activities, either alone or accompanied by staff, without being expected to talk, was something that they missed.

It appeared clear that the unsuitable premises made positive and conflict-reducing interaction between staff and patients difficult. We also found insufficient staffreflection on the overall situation of the individual patients who were subjected to long-term use of mechanical restraint and seclusion, and how a combination of different factors could contribute to high-risk situations in which coercive measures were being used.

On the whole, the NPM found many factors which contributed to increase the risk of excessive use of coercion. The risk was particularly high as we found weaknesses in the systematic work to prevent coercion for each individual patient. The conditions at the hospital clearly increased the risk that patients could be subjected to inhuman and degrading treatment through the disproportionate use of coercive measures.

Supervision and complaints

We found no posters or notices in the wards describing the rights of patients who were involuntarily admitted to the hospital.

We found that the supervisory commission, which performs regular full-day supervision visits to RSA Dikemark every fortnight, was active and thorough in its work and through this they helped to improve legal protection for the patients. We also found that the supervisory commission helped to raise staff awareness on relevant legislation and the prevention of coercive measures.

II. Recommendations

Recommendations: Physical conditions

- The hospital should immediately implement measures to ensure that the buildings and interior fittings safeguard patients' dignity, and the safety of the patients and staff.

Recommendations: Mechanical restraints

- The hospital should ensure that all staff are familiar with the legal requirements governing the use of mechanical restraints, and with the requirements regarding the continuous documented justification for such measures.
- The hospital should ensure that the use of mechanical restraints stops as soon as the conditions of "strict necessity" no longer applies, and that long-term use of mobile restraints does not become normalised.
- The hospital should ensure that patients are provided with opportunities for activity and movement, also when mobile restraints are used for long periods.

Recommendation: Spit hoods

- The hospital should ensure that spit hoods are not used. The ward should take away access to spit hoods in its inpatient units.

Recommendation: Isolation

- The hospital should make sure that all staff members are familiar with the legal requirements governing the use of isolation, and that the measures are always registered as decisions.
- The hospital should ensure that staffing considerations do not result in illegal isolation.

Recommendations: Seclusion

- The hospital should ensure that conditions resembling isolation are avoided during seclusion.
- The hospital should implement special measures to prevent the long-term use of seclusion.
- The hospital should ensure that there are opportunities for activities and movement when seclusion in a separate room is used for long periods.

Recommendation: Contact with the outside world

- The hospital should ensure that all staff are familiar with the legal requirements regarding the restriction of contact with the outside world, and ensure that the restrictions do not impact the patients' freedom of speech.
- The hospital should ensure that house rules do not impose restrictions beyond that which is legally permitted. The seizure of digital devices and visitor control may not take place unless the legal requirements are met and a decision authorising such limitations is made.

Recommendation: Institutional culture/prevention

- The hospital should record detailed statistics regarding the duration/frequency of the use of coercive measures and ensure that these data are actively used in the work to prevent future use of coercive measures.
- The hospital should ensure that patients are offered meaningful activities adapted to their interests and level of function.
- The hospital should continue the work of creating an institutional culture which promotes patient participation and as little use of coercive measures as possible, as well as strengthen its overall work on preventing the use of coercive measures.

Recommendation: Legal safeguards

- The hospital should ensure that written information about patients' rights and relevant complaints procedures is available in the common areas of all the units.

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