



**SIVILOMBUDET**  
Norwegian Parliamentary Ombud

**VISIT REPORT**

**SUMMARY AND RECOMMENDATIONS**

**Homes for Adults with Developmental  
Disabilities in Bodø Municipality**

**4. – 6. April 2022**





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## I. Summary

### **Responsibilities of the municipality**

In April 2022, the Parliamentary Ombud's National Preventive Mechanism visited six adults with developmental disabilities living in Bodø Municipality receiving an around the clock service. The subjects of the Parliamentary Ombud's visit were selected following a review of the municipality's administrative decisions on the use of coercion for seventeen people. A comprehensive administrative decision on the use of coercion had been passed for all the subjects that we visited.

In two co-localised shared housing units, we visited three residents with monitoring needs and behaviour demonstrating a high need for security, predictability and continuity. The conditions in these shared housing units, where the residents had very different levels of functioning, small apartments, few common areas and poor access to outdoor areas, created unrest and insecurity, thereby increasing the risk of coercion. The staffing situation seemed difficult, especially during holidays and at weekends, as several employees did not have healthcare qualifications. An unstable staffing situation contributed to increased risk of aggressive behaviour and the use of coercion. The staffing situation also seemed to contribute to a reduction in the number of activities that were offered to residents who needed adaptation the most. We also found that documentation on the use of coercion needed to be improved.

One of the subjects that we visited lived alone near staff accommodation. The resident needed comprehensive monitoring due to many serious incidents and a comprehensive administrative decision on the use of coercion. In practice, the resident was locked inside 24-hours a day and the only option to freely exit the apartment was into a closed outdoor area. The Norwegian Health and Care Services Act does not permit deprivation of liberty in this form. Even though the department had reduced the large number of serious incidents that occurred earlier, the resident still lived with being illegally locked inside a small apartment with an unsuitable outdoor area and few activities. The locking-in of the resident seemed an illegal deprivation of liberty. We also found that knowledge of legislation on coercion was poor, there was minimal training on techniques for gentle use of coercion, and the documentation of coercion was inaccurate. In combination, these circumstances contributed to a high risk of inhuman and degrading treatment of the resident.

Two of the subjects that we visited lived in a shared housing unit with four apartments. The services that were offered were organised and adapted in a manner that gave low risk of extensive coercion being used. The group of employees knew the residents well and the employee-resident relationship seemed to contribute to minimal coercion even though both residents behaved aggressively in periods.

The municipality's administrative decisions on the use of coercion for the residents we visited were inaccurate in several ways. Among others, the legal requirements stating that coercion must be necessary and proportionate were not adequately documented. Several of those that we met had been exposed to invasive coercion for many months, and in some cases more than a year, without a valid administrative decision. This is due to major weaknesses in the municipality's handling of administrative decisions on the use of coercion and long processing times on the part of the County Governor.

The staff, who monitored the residents that we visited, seemed to be knowledgeable about how people with considerable monitoring needs and disabilities can be helped in deciding over their own daily lives. We also found good examples of closest relatives being actively used by the staff in the continual work on preventing the use of coercion. At the same time, we talked to relatives who did not perceive they were adequately involved in shaping the services that were offered.

Some of the residents were consistently in pain, which seemed to have contributed to increased aggressive behaviour and the use of coercion. The work on screening and assessing the health condition of residents seemed fragile. Measurement and assessment tools were rarely used to objectively measure the health condition of residents, and several had not had annual health checks, as they were opposed to visiting a doctor's surgery. Several doctors did not offer home visits even though they must be offered when needed. In one department, an employee had to contact the accident and emergency department or ambulance when concerned about the residents' health. The municipality did not use individual plans as an instrument to ensure that the residents received necessary and coordinated services. The department, which consisted of a smaller shared housing unit, distinguished itself positively. Here, a nurse had been assigned the task of monitoring the residents' health, which was performed in a coordinated and rapid fashion.

Several of the residents were monitored by the specialist health service for mental health problems. This seemed to contribute to adequate mapping of drugs and discontinuation of drugs with suspected adverse effects. The specialist health service's guidance to staff, who monitored residents with particularly challenging behaviour, seemed to have contributed to less use of coercion.

No information emerged to suspect that the residents we visited had been exposed to violence or sexual abuse. At the same time, the findings indicated that the municipality should work more systematically in making employees more aware of the fact that people with developmental disabilities are at higher risk of exposure to violence or abuse.

### **Responsibilities of the County Governor**

All administrative decisions on the use of coercion were reviewed by the County Governor of Nordland. Similar to the municipality's administrative decisions, several of the County Governor's decisions did not contain sufficient justification that important legal requirements governing the use of coercion was met. Most of the administrative decisions lacked clear grounds explaining why the coercive measures were proportionate. The County Governor failed to point out the municipality's inadequate assessment of law provisions that set the threshold for carrying out mechanical restraint and seclusion. It is concerning that the County Governor disregards direct requirements of the law. In one of the cases, the County Governor had disregarded the fact that the law does not permit around the clock locking-in of residents. Such law violations represent a high risk of inhuman or degrading treatment.

During the course of the last five years, all residents went for many months, and in some cases much longer, without an approved administrative decision on the use of coercion. This was partly due to the County Governor's case processing times. One of the resident's administrative decision was never reviewed because of a difficult resource situation. The individual was exposed to comprehensive physical coercion for almost eight months before the municipality submitted a new

administrative decision, which was approved. In another case, the County Governor spent more than nine months reviewing an administrative decision. The overall consequence was that the resident had a non-valid comprehensive administrative decision on the use of coercion for almost one year and nine months. Large-scale use of extensive coercion without a valid administrative decision on the use of coercion is serious.

Two of the residents that we visited had not received on-site supervisory visits during the last five years even though multiple risk factors indicated that such visits should have been conducted.

All the residents that we visited had been appointed a guardian. The County Governor shall provide the necessary training and guidance for guardians. Our findings indicate that guardians did not receive enough training and guidance to safeguard the legal protection of residents in cases regarding extensive coercion. Further, the guardians felt they did not receive enough guidance from the County Governor regarding available appeal options.

## II. Recommendations for the municipality

### Decisions on the use of coercion

- The municipality must ensure that administrative decisions and decisions on the use of coercion satisfy the conditions of the law and provide adequate grounds for doing so.
- The municipality should strengthen the internal quality assurance of decisions in acute risk-situations and administrative decisions on the use of coercion.
- The municipality must ensure that new decisions are sent to the County Governor promptly and that decisions that are not authorised by the County Governor are followed up immediately and resubmitted for review.

### Use of extensive coercion in the homes

- The municipality should ensure that all offered housing is planned and adapted in a manner that enables residents to feel safe without exposure to unnecessary physical coercion and seclusion.
- The municipality must ensure that when any physical coercion and seclusion is carried out it is documented in the residents' records.
- The municipality must implement measures to ensure that the offered services are adapted in a manner that does not lead to illegal deprivation of liberty.

### Staffing and competence

- The municipality should strengthen its work on training, so all employees are sufficiently knowledgeable about the conditions for using coercion pursuant to the Norwegian Health and Care Services Act, Chapter 9.
- The municipality should arrange for employees to receive regular training on the prevention of challenging behaviour and gentle coercion techniques.

### Health monitoring and habilitation

- The municipality should strengthen its work on ensuring that the residents' health condition and pain are mapped and followed-up by the staff.
- The municipality should implement measures to ensure that residents with challenging behaviour receive adapted access to medical services, including home visits when necessary.
- The municipality should ensure that residents with complex and comprehensive health problems are offered individual plans and a coordinator.

### Protection from violence and abuse:

- The municipality should prepare defined routines for preventing and handling violence and abuse against the residents.
- The municipality should implement measures to increase the awareness and knowledge of staff about violence and abuse to enable them to prevent, recognise and handle such incidents.

### III. Recommendations for the County Governor

#### Reviews

- The County Governor must ensure that the municipality's administrative decisions are checked, so all use of extensive coercion is only exercised when the associated conditions are satisfied and the legal assessments are clearly stated in the grounds for the decision.
- The County Governor should ensure that administrative decisions are reviewed by the applicable deadline, and that unauthorised decisions on invasive restraint are followed up within a reasonable time frame, and that the municipality receives the necessary guidance.

#### Supervision

- The County Governor must ensure the conduction of on-site supervision when an administrative decision on the use of coercion is approved, and otherwise when the nature of coercive measures and other risk factors indicate supervision.
- During on-site supervision visits, the County Governor should offer conversations with residents, who have received an administrative decision on the use of coercion, if possible. Regardless of this, the supervising person(s) should try to meet the resident.

#### Training and guidance for guardians

- The County Governor should ensure that everyone, who receives an administrative decision on the use of coercion pursuant to the Norwegian Health and Care Services Act, Chapter 9, is appointed a guardian with a mandate covering the tasks related to the legislation.
- The County Governor should ensure that all appointed guardians receive enough training and guidance to safeguard the legal protection of residents when extensive coercion is used.



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View over Bodø. Photo: Sivilombudet