SIVILOMBUDET
Norwegian Parliamentary Ombud

VISIT REPORT | no. 75

SUMMARY AND RECOMMENDATIONS

Bredtveit prison
and Ullersmo prison, dept. Zulu Øst

13.–16. March 2023

National Preventive Mechanism against
Torture and Ill-Treatment

SIVILOMBUDET
Norwegian Parliamentary Ombud

VISIT REPORT

Bredtveit prison
and Ullersmo prison, dept. Zulu East

13. - 16. March 2023

Table of content

I. The Parliamentary Ombud's prevention mandate

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

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture), adopted in 1984, plays a central role in this. The same prohibition is also embodied in the UN International Covenant on Civil and Political Rights (Article 7), the UN Convention on the Rights of the Child (Article 37), the UN Convention on the Rights of Persons with Disabilities (Article 15) and the European Convention on Human Rights (Article 3). Norway has ratified all of these conventions.

People who have been deprived of their liberty are vulnerable to violations of the prohibition against torture and inhuman treatment, which is why the UN adopted an optional protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 2002.

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

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

The risk of torture or inhuman treatment is affected factors such as legal and institutional frameworks, physical conditions, training, resources, management and institutional culture.[2] Effective prevention work therefore requires a broad approach that does not focus exclusively on whether the situation complies with Norwegian law.

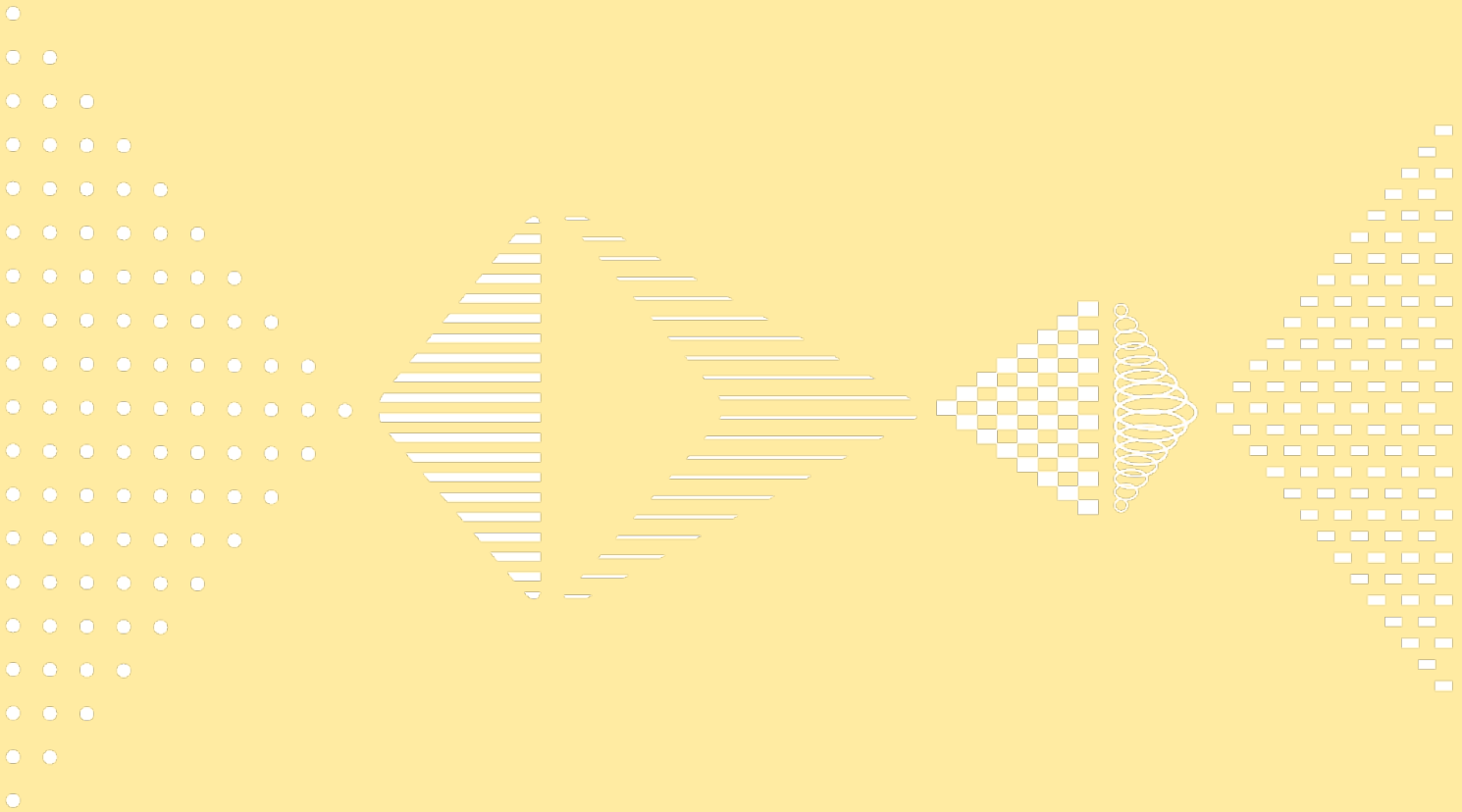
The Parliamentary Ombud’s assessments of conditions that pose a risk of torture and inhuman treatment are based on a broad range of sources. During the visits, the national preventive mechanism examines the conditions at the location through observations, interviews and documentation reviews. Private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

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

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

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

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



II. Summary

During the period 13–16 March 2023, the National Preventive Mechanism of the Parliamentary Ombud conducted an unannounced visit to Bredtveit Prison and the Zulu East wing at Ullersmo Prison.

The visit took place as a result of increasing concerns regarding conditions at Bredtveit Prison and the transfer of female inmates to Ullersmo men's Prison in January 2023 as an emergency measure. Through numerous prison visits and in the 2016 thematic report "Women in prison", the Parliamentary Ombud has expressed its concern that female inmates are collectively afforded inferior prison conditions compared with men. Recent research has also shown that the proportion of female inmates with mental health challenges rose considerably during the period 2010–2019.

Our visit revealed that the inmates at Bredtveit Prison were living under critical and even life-threatening conditions. The seriousness of the situation and the need for urgent measures led the Parliamentary Ombud to notify the Ministry of Justice and Public Security of the conditions in a letter dated 23 March 2023.

In addition to observations and more than 50 interviews of inmates and staff in both the prisons and the specialist health service, this report is based on extensive written material, including procedures, administrative decisions, protocols, duty records and ongoing records from prison and medical records, along with descriptions of procedures from the health services.

The Parliamentary Ombud's visit revealed serious failings at Bredtveit Prison, the Norwegian Correctional Service's regional office and within the prison health service. This has had serious consequences both for individual inmates and the prison as a whole. The failure of the responsible authorities to adequately follow up these unacceptable conditions gives cause for concern that the conditions at Bredtveit Prison also reflect broader challenges within the correctional services in Norway.

Illegal use of solitary confinement

Solitary confinement can harm the health of inmates even after a short period of time, and the negative health effects can linger long after the solitary confinement has ended. Inmates who are young, suffer from mental health problems or developmental disabilities are particularly vulnerable to developing adverse effects caused by solitary confinement. During the period 2018–2022, the prison recorded a doubling of inmates being placed in solitary confinement in their cell (from 36 inmates in 2018 to 77 in 2022).

Since 2018, the prison has more than doubled the number of inmates it has placed in security cells, the most intrusive form of solitary confinement that a prison can impose (from 27 decisions in 2018 to 92 in 2022). A security cell is a bare cell with only a plastic mattress and a squat toilet. Food and water are pushed in through a hatch at floor level and no washing facilities are provided for the inmates. Most of the communication between the inmate and staff takes place through small hatches or plexiglass. While in a security cell, inmates are deprived of virtually all control over their own life, to a far greater extent than that which follows from the imprisonment itself.

Most of the decisions concerning placement in security cells that we reviewed did not fulfil the applicable statutory requirements. Many cases that we examined, indicated poor conflict prevention,

threats or violent acts that could have been foreseen. Examples include stress and worry in connection with impending court hearings or frustration over inactivity and a lack of association with other inmates, which in turn contributed to further escalation which was then dealt with by placing the inmate in a security cell. In many cases, the inmate was carried from the third floor to the security wing, which forms a ground floor extension, wearing handcuffs.

By law, ongoing assessments must be made of whether or not the use of a security cell is strictly necessary, and the stay must be brought to an end as soon as this is no longer the case. The prison's efforts to fulfil these requirements consistently appeared to be very inadequate. We saw numerous examples of decisions being made in the afternoon to place an inmate in a security cell until the following day. In some cases, the inmate was described as being calm when the decision was made and there was no information in the documentation to indicate that the inmate needed to remain in the security cell.

The efforts of the prison to prevent the adverse health effects of solitary confinement were also inadequate. We found virtually no documentation which indicated that inmates who had been in solitary confinement (placed in isolation in their own or a reinforced cell) had been offered the opportunity to engage in social contact, which met the minimum requirement of two hours' meaningful human contact per day. We also found no examples of inmates in security cells being given the opportunity to get out into the open air, even when their stay in a security cell lasted several days. There was a dedicated resource team at the prison which was responsible for preventing solitary confinement damage by following up on and activating individual inmates. This resource team was doing an important job, but it had very limited capacity and was therefore unable to meet the needs of inmates in solitary confinement at the prison.

The visit and subsequent review of documentation revealed that the prison is failing to comply with the requirement that solitary confinement must only be used in extraordinary cases, as a last resort and for as short a period as possible. It appeared that the prison consistently had a low level of understanding of both the considerable health risks linked to solitary confinement and the legislative boundaries of its use. The Norwegian Correctional Service's eastern regional office, which is responsible for the execution of sentences at Bredtveit, also appears to have failed to identify these shortcomings.

Widespread and serious failings in the prevention of suicide and self-harm

Between 2018 and 2022, Bredtveit Prison recorded a twenty-fold increase in self-harm incidents. In 2022, a total of 145 self-harm incidents linked to 14 inmates were recorded. Despite this, the prison had no system in place for identifying and following up the risk of self-harm and suicide, both upon admission and during the stay in prison. When we asked to see the prison's plans for the prevention of suicide and self-harm for inmates at risk for the period January 2022 to March 2023, we were only given one single plan for one inmate.

It is well-documented that solitary confinement can increase the risk of suicide, self-harm and the development of severe mental health problems. The prison largely dealt with self-harm and indications of suicide risk by solitary confinement and the use of force. A review of decisions made concerning the use of security cells during a sample period, showed that 16 out of a total of 23 decisions were taken as a result of concerns about self-harm and suicide risk.

We encountered inappropriate and, what appeared to us, routine escalation of intrusive measures: from isolation in the inmate's regular cell to placement in a security cell and, in some cases, the use of a restraint bed (belt fixation). The prison's use of a restraint bed increased from two cases in 2018 to 26 cases in 2022. The use of solitary confinement and intrusive coercion with respect to inmates in crisis can reduce the likelihood that inmates at risk share information about their mental health and suicidal thoughts with the staff.

There is considerable evidence to suggest that, in recent years, Bredtveit has had a higher number of individual inmates facing serious mental health challenges than was previously the case. The prison consistently referred to the healthcare department and the outpatient clinic as being responsible for safeguarding members of this group, who are often suicidal and self-harming. There was also little awareness of how the prison's own operation, internment conditions and use of solitary confinement impact on all its inmates and could increase the risk of mental illness, self-harm and suicide.

The prison's efforts to prevent suicide and suicide risk overall appeared to be inadequate, non-systematic and not sufficiently knowledge based. This increases the risk of the prison not fulfilling its obligation to safeguard the inmates' right to life.

Two days before the Parliamentary Ombud's visit, one of the prison's inmates committed suicide. Documentation of the conditions under which this inmate was serving their sentence and the follow-up of their health, revealed that changes need to be made in how the prison works on suicide prevention, as well as evaluation and learning following an inmate suicide. For reasons of confidentiality, we will not describe the results of the investigation in any more detail in this report. A review and evaluation have been shared with the prison, the healthcare department and the prison's psychiatric outpatient clinic. The supervisory board for Bredtveit Prison was not informed of the incident by the prison.

Poor prison conditions

Most inmates that we spoke to expressed considerable frustration and concern over conditions in the prison and found their everyday lives to be unpredictable. Many inmates mentioned the constant turnover of prison officers and the frequent use of temporary staff, which made it difficult to establish positive relationships with the prison staff. The extensive use of solitary confinement, particularly security cells, had negative consequences for the rest of the prison.

Many inmates explained that it was a considerable additional burden to have to serve their sentence alongside inmates who self-harmed and struggled with mental health problems. They talked about long periods when they could hear other inmates banging their head against the floor or a wall, kicking cell doors and furniture, or shouting and crying out loud. Many of them said that their own mental health had suffered considerably as a result of living in close quarters with other people with mental health problems. In some cases, it appeared that the inmates' own sense of insecurity and lack of stability triggered situations which led them to being placed in a security cell.

The staff's perception of stress, powerlessness and time pressure increases the risk of force being used disproportionately. It was obvious that the staff were working under very difficult conditions and with very low staffing levels. The visit revealed numerous examples of the disproportionate use of force on inmates. Incidents were encountered where the use of considerable physical force had resulted in injury, and one inmate was deprived of their mattress and had to sleep on the concrete

floor in a security cell for several days. There were also numerous cases where inmates were threatened with the use of force.

Critical failure in staffing and leadership

Many of the conditions that the National Preventive Mechanism encountered appeared to be directly caused by weaknesses in staffing and leadership at the prison.

Staffing levels at the prison were so low that any unplanned absence had serious consequences for the running of the prison and therefore directly impacted on the inmates. It was clear that staffing challenges led to cancelled rehabilitation measures such as activation, access to fresh air, meaningful human contact. In many cases, the members of the resource team were drawn into the daily running of the prison and were therefore unable to carry out their tasks aimed at preventing long-term solitary confinement among female inmates experiencing severe mental health problems.

In many important areas, there were no procedures or systems in place to ensure that plans and core tasks were implemented. Among other things, there was no systematic work being carried out to deal with the extensive and constantly increasing challenges relating to self-harm and the resultant use of coercion. Conversations with staff revealed considerable and extensive uncertainty concerning work relating to health, safety and environment and on how non-conformities were followed up. There were also no procedures in place for the provision of support for staff who were under great stress over an extended period of time. Guidance and support for staff appeared to be unsystematic and inadequate.

We found serious gaps in the prison's documentation, for instance concerning the use of cell confinement (the locking of all inmates in their cells), intake meetings and suicide risk.

The Correctional Services have on several occasions pointed out that there are inmates who, as a result of various types of illness and possibly in combination with a low level of functioning, should not be in prison. Nevertheless, the prison appears to have made insufficient use of its ability to influence custody placements in the prison or admission to the mental health service.

Major weaknesses in health services provided for inmates

In Norway, the prison health service is run by the municipal authorities as primary health care provider, even if the services are localised within the prison. Some prisons also have the regional specialist health services present. What is known as 'the import model', where the health service is independent of the Correctional Service, supports the medical personnel's independence of the Correctional Service. The import model is intended to ensure that medical personnel never partake in administrative decisions on sanctions or in enforcing sanctions.

The municipal healthcare department (Bjerke District), the psychiatric outpatient clinic for the inmates (Specialist health services provided by Oslo University Hospital) and the prison described positive collaboration with the other respective parties. Yet, there were also striking differences in how they described conditions at the prison. The healthcare services did not express any concerns regarding the use of security cells or restraint beds for inmates who self-harmed or were considered suicidal, even though the use of such coercive measures had increased sharply and the prison management described this as a key challenge. The management level within the two healthcare services did not hold regular meetings with each other and we found no evidence of any general collaboration aimed at improving the health situation for the prison inmates.

The follow-up of inmates in solitary confinement by the healthcare department was inadequate. The department did not independently consider the health-related consequences of using solitary confinement and security cells for individual inmates. They also had no general overview of how long inmates spent in solitary confinement or the reason for the solitary confinement, not even in cases where the solitary confinement was justified through suicide risk. We found no systematic recording of injuries suffered by inmates while they were in solitary confinement. The department also lacked procedures for supervision in connection with exclusion and the use of security cells. There was no evidence to suggest that they carry out daily supervision of inmates who had been excluded from interaction with other inmates, even though the Directorate of Health's guidance stipulates that such supervision must be carried out.

The handling of medicines at Bredtveit Prison was inadequate and constituted a risk to the safety of the inmates as patients. Medicines were stored unlocked in the prison officers' duty room, and there was no overview of the inmates who had been given medicines. We saw numerous examples where these circumstances had given rise to a risk of poisoning and incorrect treatment. In cases where prison officers contacted the healthcare department in order to obtain more medicine after some had disappeared, no reason was given for the disappearance and the deviation was not registered.

The healthcare department's records rarely contained any summary notes or minutes from collaborative meetings with external bodies, not even in cases of long and complex patient treatments. Documentation of relevant and necessary medical information was inadequate and arbitrary, and there was no overview of the inmates' treatment plans. For example, when the emergency medical service had examined an inmate in a security cell, we found no evidence to suggest that the assessment had been followed up or noted in the healthcare department's records. We also found examples where important information, such as tasks sent by the prison's psychiatric outpatient clinic to the healthcare department, had not being recorded by the healthcare department.

The healthcare department did not offer inmates the opportunity to be treated by a female doctor. Many inmates explained that they did not want a male doctor to examine them, because they had previously been subjected to sexual assault and violence. Some inmates felt pressured by the healthcare department into agreeing to allow the male doctor to examine them. The healthcare department's lack of provision for inmates who wished to be seen by a female doctor reduced the inmates' trust in the health service and increased the risk that inmates missed out on important medical examinations.

A review of medical records from the prison psychiatric outpatient clinic indicated that these records were generally thorough, including the review and evaluation of suicide risk. Telephone interpreters/video links were used when necessary, and there were minutes of collaborative meetings between external and internal bodies. The outpatient clinic generally stated that they had a good level of expertise and were well-staffed for their tasks. This was confirmed through the document review.

Unacceptable conditions for women transferred to Ullersmo Prison

The Parliamentary Ombud is critical of the decision to transfer female inmates to the Zulu East solitary confinement wing at Ullersmo Prison on 27 January 2023. The women were placed in a prison where there was no opportunity for interaction with other inmates. This led to concern as to

whether the conditions for exclusion were actually met in individual cases. The transfer meant that the prison was unable to fulfil its obligation to prevent solitary confinement, as the physical placement of the inmates did not make it possible to end the exclusion.

We also considered it very unfortunate that the women were transferred to a wing where also male inmates were placed. As inmates were able to hear each other between their cells, the women were subjected to sexualised language and approaches from the male inmates. Cells and cell hatches consistently had to be kept locked to avoid male and female inmates meeting each other. It was not possible for the female inmates to use the gym room or the extensive yard at the prison without encountering male inmates.

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

Recommendations for Bredtveit Prison

Solitary confinement and exclusion from association with other inmates

- The prison should ensure that all inmates who are not in solitary confinement can spend at least eight hours outside their cell every day and take part in meaningful activities, including at weekends.
- The prison should work systematically to reduce the use of solitary confinement and prevent negative health effects caused by solitary confinement. The prison should work to safeguard inmates who are particularly vulnerable to negative health effects linked to solitary confinement, including young inmates.
- The prison should implement measures to prevent prolonged solitary confinement, including proactive measures to end the isolation as well as ensuring that frequent assessments are made to see whether isolation is still necessary.
- The prison should ensure that all inmates in solitary confinement are offered at least two hours of meaningful human contact every day, and that individual plans are drawn up to ensure that this is carried out and documented.
- All inmates, including those in solitary confinement, should be offered the chance to spend at least one hour outdoors every day.
- The prison should implement measures to ensure that all decisions concerning solitary confinement are taken in accordance with law, with a specific justification which confirms that the conditions stipulated in the law are met. It shall always be stated why solitary confinement is strictly necessary. The solitary confinement must be assessed on an ongoing basis and cease as soon as the conditions for solitary confinement are no longer met.
- The prison should ensure that inmates can see a clock from both of the security cells.
- The prison should find a solution for distributing food, beverages and sanitary articles to security cells, which ensures inmates' dignity.
- The prison should implement measures to ensure that inmates who wish to contact a lawyer while placed in a security cell or on a restraint bed are able to do so.

Self-harm, suicide attempts and suicide

- The prison should implement measures to ensure that all inmates are assessed for suicide and self-harm risk, both upon admission and during their stay in prison.

- The prison should ensure that inmates who are at greater risk of suicide and self-harm are met with knowledge-based preventive measures, such as increased human contact, care and activation. Solitary confinement should not be used to prevent self-harm and suicide.
- Use of the prison's restraint bed should be abolished.
- The prison should ensure that information concerning inmates' mental health problems and suicidal thoughts in remand orders and from other external actors is followed up systematically.

The prison environment

- The prison should work systematically to ensure satisfactory detention conditions for all inmates.
- The prison should implement measures to ensure that staff do not use disproportionate physical force, including in connection with the transfer of inmates.
- The prison should offer interpreters in connection with admission reviews for all inmates who do not have adequate language skills. While inmates are in prison, an interpreter should be used when important information is to be provided or an inmate wishes to communicate information to the prison. Offers and use of interpreters should be documented.
- The prison should provide suitable detention conditions for persons with various functional impairments and ensure access to the necessary technical aids.
- The prison should ensure that male staff are not present during body searches performed on inmates.

Failure in leadership and staffing

- The prison should immediately implement measures to ensure the systematic follow-up and safeguarding of staff at all levels.
- The prison should ensure that staff take part in regular training and skills development measures which enhance their ability to safeguard inmates in an appropriate manner.
- The prison should ensure that the resource team is not used to cover staff shortages.
- The prison should improve its documentation procedures.
- The prison should have procedures in place for determining the instruments to use when the prison believes that an individual inmate should not continue to stay in prison.

Recommendations for the Norwegian Correctional Service, Eastern Region

- The Norwegian Correctional Service, Eastern Region should implement measures to ensure that they carry out individual evaluations to determine whether the conditions for continuing solitary confinement are still met. Evaluations of proportionality in connection with prolonged solitary confinement must always include individual vulnerability factors.

Recommendations for Bjerke District, prison psychiatric outpatient clinic (Oslo University Hospital) and the prison

- Bjerke District, prison psychiatric outpatient clinic and the prison should work together to implement low-threshold health promotion measures. These should include measures to prevent suicide and self-harm, and ensure that inmates do not become isolated if they self-harm or are considered to be suicidal.

- The prison and prison psychiatric outpatient clinic should work together to ensure that the outpatient clinic's expertise is used to guide and teach the prison's staff.
- The prison should ensure that suitable premises are provided for the health services.

Recommendations for Bjerke District and the prison

- Bjerke District and the prison must jointly establish and maintain systems for the safe and appropriate handling of medicines and follow-up of non-conformities.
- Bjerke District and the prison must ensure that communication between inmates and the healthcare department takes place in a manner which safeguards the inmates' right to confidentiality.
- Bjerke District and the prison should each maintain an overview of cancelled and postponed appointments for health services.
- When it is decided that inmates are to be relocated to another prison, the prison must ensure that the healthcare service is involved as quickly as possible to ensure that patient information is transferred after consent has been obtained from the patient.

Recommendations for Bjerke District

- Bjerke District should ensure adequate record-keeping.
- Bjerke District should ensure that medical needs are reviewed and evaluated upon admission and no later than within 24 hours. All new inmates that are admitted to the prison outside working hours should undergo a health assessment by an emergency medical service doctor.
- Bjerke District should ensure that suicide risk is reviewed and evaluated, including serious and/or repeated self-harm, both upon admission and while the inmate is during their stay in prison.
- Bjerke District should ensure the daily supervision and follow-up of inmates in solitary confinement, including those who are excluded from association with other inmates. The District should ensure that it has a comprehensive overview of completed supervisions, including when such supervision is carried out by the emergency medical service.
- Bjerke District should keep a systematic overview of all inmates who are in solitary confinement, the reason for the confinement, how long the confinement lasts and the negative health effects of the confinement.
- Bjerke District should have a procedure in place which describes how the healthcare department should report inadequate conditions for good health follow-up, conditions that are harmful to health, and concerns regarding the fitness of inmates to serve their sentence.
- Bjerke District should ensure that inmates have access to a female doctor.
- Bjerke District should ensure that patients with complex, serious or long-term medical problems receive comprehensive, coordinated follow-up.
- Bjerke District should secure sufficient capacity to implement preventive and health-promoting measures aimed at inmates.
- Bjerke District should ensure that all enquiries from inmates to the healthcare department and subsequent responses are recorded. In the response from the healthcare department, inmates should be given a specific time for a consultation.
- Bjerke District should have a camera available so that any injuries suffered by inmates can be documented by healthcare personnel in the inmate's health record.

- Bjerke District should ensure a more systematic use of interpreters in meetings with the healthcare service.

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

Photo: Sivilombudet