

VISIT REPORT no. 74	
Den skreddersydde enhet	
1.– 3. february 2023	

National Preventive Mechanism against Torture and III-Treatment



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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.

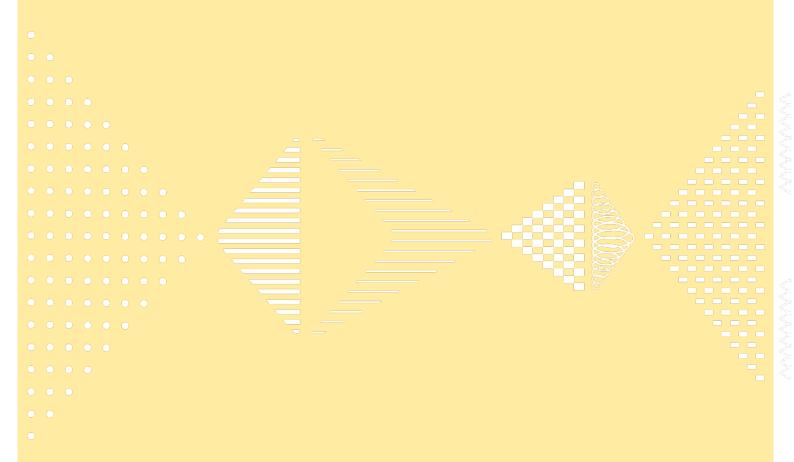
After each visit, a report is written, describing findings and recommendations for how the facility in question can prevent torture and other cruel, inhuman or degrading treatment or punishment.

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

In December 2022, Den skreddersydde enhet AS was notified that the Ombudsman would conduct a visit to one or more of their child welfare departments during the first half of 2023. The visit took place from February 1 to February 3, 2023, and covered four departments in the Agder region. The main focus of the visit was children living alone with staff in institutions.

Risk when children live alone in institutions

In all the departments visited, one child lived alone with the staff. At the time of the visit, all had been living alone for at least four months, with one child having lived alone in their department since 2017.

Even though all the children had been living alone for some time, documentation showed regular assessments for only one of them regarding whether it was in the best interest of the child to live alone. The Ombudsman found a lack of similar documentation for the other departments. It was also challenging to assess whether the youth's perspective on living alone was systematically examined.

Overall, it appeared that the youth visited had opportunities to be with peers, maintain contact with people outside the institution, such as friends and family, and generally move freely with access to electronic communication tools like their mobile phones.

Given the significant impact on a child living alone in an institution, the Ombudsman believes there should be consideration of the need for guidelines to ensure such assessments are conducted. This matter will be raised with relevant authorities.

Protection against violence and abuse

The institution had written procedures for preventing and handling abuse. However, the staff seemed to have limited knowledge of these procedures. The Ombudsman emphasizes the importance of ensuring that protection against violence and abuse is a regular topic of discussion and reflection among staff and with management. Procedures for reporting must ensure that the youth living in the institutions are informed about how to safely report if a violent or abusive act has occurred.

Use of force

During the visit, it became apparent that there was a certain degree of uncertainty among the staff on how to handle situations where a youth was threatening or acted out, and when staff must use physical force to avert immediate danger to life, health, or significant property damage. If staff have varying understandings of when and how to handle such situations, it could result in more intrusive use of force than necessary.

In an institution where only one youth reside, there are usually only two staff members present to handle acute emergency situations. This could lead to the use of relatively more force to manage the situation, increasing the risk of harm or non-gentle use of force. This makes the work of preventing conflict-filled situations and the use of coercion even more critical.

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

Assessment of whether it is in the child's best interest to live alone

• For children who live alone for an extended period, it is crucial for the institution, in collaboration with child welfare authorities, to conduct systematic assessments of whether it is in the child's best interest to live alone. The child's ability to express their opinion on this matter must be ensured.

Prevention of social isolation

• The institution should ensure that the risk of social isolation when children live alone with adults is continously assessed for each child and followed up with specific adjustments.

Protection against violence and abuse

- The institution should implement measures to increase staff awareness and knowledge of abuse, enabling them to prevent, detect, and handle such situations.
- The institution should ensure that procedures make it clear how children themselves can report abuse and that they are informed about these procedures.

Scope and documentation of coercion

• The institution must ensure that the description in decisions on how intrusive coercion measures are carried out is sufficiently detailed.

Use of physical force

• All staff and substitutes should receive uniform training and education in the use of intrusive physical force.

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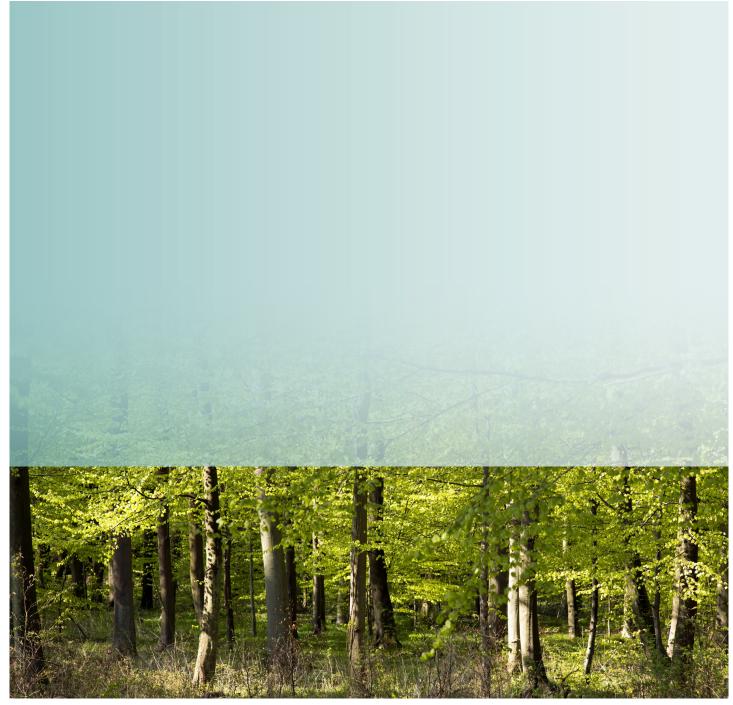


Photo: Colourbox