SIVILOMBUDET

Norwegian Parliamentary Ombud

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

ANNUAL REPORT 2023

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Our Mandate

The prohibition on torture and other cruel, inhuman or degrading treatment or punishment is established in the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture). 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 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 (OPCAT) in 2002.

The protocol requires that states establish a national preventive mechanism (NPM) 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] In Norway, the national preventive mechanism (NPM) is established as a separate unit at the Parliamentary Ombud (Sivilombudet) in accordance with the Parliamentary Ombud Act of 2021.[2]

The NPM has access, and can conduct visits to all locations where persons are or may be deprived of their liberty. These places range from prisons and police custody facilities to mental health care institutions and child welfare institutions.

Visits are usually semi-unannounced, as the institution is told there will be a visit, but not exactly when it will occur. The NPM 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 by factors such as legal and institutional frameworks, physical conditions, training, resources, management, and institutional culture.[3] Effective prevention work, therefore, requires a broad approach that does not focus exclusively on whether the situation complies with Norwegian law. To ensure this broad perspective, the Norwegian NPM team is interdisciplinary and is made up of staff with backgrounds in law, psychology, and social sciences.

The NPM's assessments of conditions that pose a risk of torture and inhuman treatment stem from a broad range of sources. During the visits, we examine the conditions at the location through observations, interviews and documentation review. Private interviews with persons deprived of liberty are important sources of first-hand information about the conditions. Staff, management, and other relevant parties are also interviewed. Furthermore, documentation, such as guidelines, decisions, logs, and health documentation, is obtained to clarify the conditions at the location.

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

1 Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, articles 17-23.
2 Section 1, 17, 18 and 19 of the Norwegian Parliamentary Ombud Act.
3 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 our endeavours to fulfil the preventive mandate, the NPM also engages in extensive dialogue with national authorities, control and supervisory bodies in the public administration, civil society and international human rights organisations.

The NPM visiting Agder Prison, Froland department in November 2023.
Photo: Parliamentary Ombud/NPM

The Year at a Glance

This has been a busy and productive year for the national preventive mechanism. We have completed visits to child welfare institutions, prisons, and holding cells at Oslo Courthouse. In the country's largest prison for women, Bredtveit Prison, we uncovered critical and life-threatening conditions for the inmates. As a result, we submitted an urgent notification to the Ministry of Justice and Public Security. Several extraordinary measures were implemented by the authorities.

The national preventive mechanism (NPM) had originally not planned a visit to Bredtveit Prison in 2023. At the beginning of the year, however, we received several concerning reports about the conditions in the prison. In February, several of the female inmates were urgently moved to Ullersmo Prison, a men's prison, to protect the inmates' lives, safety and well-being. Considering this serious development, we decided to adjust our visitation schedule for the spring and make an immediate and extensive visit to the prison, where we also looked more closely at the health services provided for the inmates.

We uncovered untenable prison conditions and serious shortcomings, on the part of both the Norwegian Correctional Service and Bjerke District's healthcare department, which provides primary health care to the female inmates at Bredtveit. Several of the inmates we met, struggled with serious mental health issues. Conditions at the prison had been deteriorating over an extended time, and records showed a twenty-fold increase in self-harm incidents from 2018 to 2022. In some cases, we also found disproportionate use of force. Shortcomings in routines, staffing levels, preventive activities and employee follow-up further exacerbated an already difficult situation at the prison. For more information, please see the article about this visit on page 24.

Shortly after our visit, the NPM sent an urgent notification directly to the Ministry of Justice and Public Security, where we informed the Ministry of the serious conditions in the prison and emphasised the need for immediate action to protect the inmates' fundamental rights. This is the first time we have presented an urgent notification to national authorities. Normally, we do not comment on our findings before the report from the visit has been finalised. However, the conditions at Bredtveit Prisons were so serious that we had to act without delay.

After our notification, several immediate measures were implemented at Bredtveit Prison. Staffing levels were increased and the number of inmates was reduced. A decision was made to convert Skien Prison into a new prison for women, and to establish a special prison unit with higher level of care for female inmates with severe mental health challenges. These are urgent and necessary measures. At the same time the prison sector is characterised by tight funding, unsuitable buildings, and major staffing challenges. In November, Statsbygg, the Norwegian government's property manager, recommended closing down Bredtveit Prison due to concerns about fire safety. The Norwegian Correctional Service has announced that all female inmates will be moved to Skien and Romerike Prison at Ullersmo by 1 March 2024. We will monitor this development closely, and we expect that the Norwegian Correctional Service will find permanent and good solutions for the women who, until now, have served time in Bredtveit Prison.

The Parliamentary Ombud's National Preventive Mechanism unit. From left: Aurora Lindeland Geelmuyden, Johannes Flisnes Nilsen, Tonje Østvold Byhre, Parliamentary Ombud Hanne Harlem, Helga Fastrup Ervik, Jakob Mykland Revheim, Mette Jansen Wannerstedt, Karin Afeef and Anne Bitsch. Photo: Mona Ødegård.

Our visit to Bredtveit Prison also highlighted general concerns about the correctional services in Norway and the need to carry out more prison visits. Prison officers, inmates, family members, and civil society organisations tell us about censurable conditions for inmates across the country. There are also indications that opportunities for meaningful human contact and activity are reduced because of cost-cutting measures. As such, we decided to carry out three additional prison visits to Halden, Froland, and Bodø Prisons in the autumn of 2023. Reports from these visits will be published in the spring of 2024. We are also planning further prison visits in the coming year.

In addition to prison visits, we visited eleven different child welfare institutions in Agder County at the beginning of the year. These were institutions where young people lived on their own with adult staff. From previous visits, we know that these types of institutions may lead to a heightened risk of ill-treatment and social isolation. It was encouraging to see that the young people we met in Agder had the opportunity to spend time with peers and stay in touch with people outside of the institution. The NPM nonetheless believes that the authorities should consider whether special rules or national regulations are needed to ensure regular assessments of whether it is in the child's best interest to live alone with adults in this way. There is also a need for better and clearer regulations and guidelines regarding the use of force in child welfare institutions.

In the spring of 2023, we published reports from our visits to secure psychiatric units at the regional level in Dikemark, Trondheim, and Bergen in 2022. (For more information about our findings, please see the article on page 31). This autumn, we have presented our findings to both the supervisory commissions and various professional and research communities in the field of high-security psychiatry. In addition, we have provided feedback to the committee established by the government to evaluate preventive detention, transfers to compulsory mental health care, and compulsory care. We will continue to monitor the developments in this field and contribute with our expertise and experience where possible.

In the autumn, we carried out a brief visit to the holding cells at the Oslo District Court. These holding cells are operated by the Oslo Police District and are used to hold detained persons who are attending proceedings in the court. While the stay in the holding cells is relatively short, the risk of violation of the rights of the person in custody is still present.

In 2023, we also had to follow up on conditions at the Police Immigration Detention Centre at Trandum. In a civil case that concerned a former detainee, we presented a brief for clarification of broad public interests (amicus curiae) to the Borgarting Court of Appeal. The court concluded that the routine body searches and lockdowns the detainee had been subjected to at the detention centre constituted a violation of Articles 3 and 8 of the European Convention on Human Rights. The court judgement was not final as of December 2023.

Unfortunately, the work to improve the censurable conditions at Trandum and clarification of the regulations regarding immigration detention in Norway is taking a long time. This stands in contrast to the serious conditions that have been pointed out over time, by several national and international bodies.

While change may take time, we do see that our work makes a difference, also at the national level. In February, the Ministry of Justice and Public Security sent a proposal for amendments to the Execution of Sentences Act out for consultation, with clear reference to the recommendations we made in our special report to the Storting on solitary confinement (2019). The proposal includes several good amendments. We are, however, critical of the proposed provisions concerning inmates' association with others and protection against solitary confinement. Our assessment of the proposal is that it does not sufficiently protect inmates' fundamental rights.

Photo: Mona Ødegård

In the past year, we have also commented on the draft national guidelines on municipal health and care services for prison inmates presented by the Norwegian Directorate of Health. This, too, is a follow-up of a recommendation we gave in our special report to the Storting.

Hanne Harlem
Parliamentary Ombud

Visits in 2023

The core task of the national preventive mechanism (NPM) is to visit places where people are, or can be, deprived of their freedom. 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. This section provides information about the visits carried out in 2023.

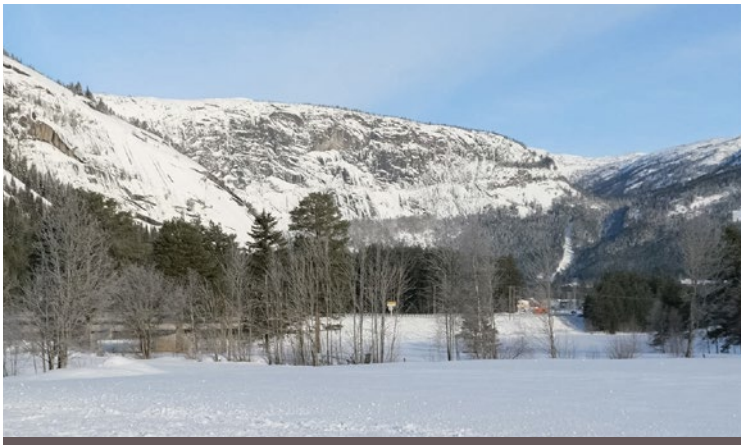

Photo: Parliamentary Ombud/NPM

Visit 72: Humana care and assistance, Kristiansand (child welfare institutions)

Visit conducted: January 2023
Report published: May 2023
Status 31.12.2023: Awaiting feedback from the institution

In October 2023, the NPM received feedback on how Humana Kristiansand had followed up on the recommendations from the report. The response from the institution was brief, and on some points, it was difficult to determine which follow-up measures had been implemented in response to specific recommendations. One example is that Humana Kristiansand has established a new procedure for preventing and managing abuse in the wake of our visit. While this is positive, the establishment of procedures is not, in itself, a satisfactory response to our recommendations. We have therefore asked Humana to send us additional information on how the new procedures are applied in the day-to-day work. After a further response from Humana in December 2023, it remained unclear what kind of information the children receive about who to contact if they experience abuse in the institution. We have therefore asked Humana Kristiansand to send us more information about this issue.

Visit 73: Haraldsplass Serio Ung, Agder (child welfare institutions)

Visit conducted: February 2023
Report published: May 2023
Status 31.12.2023: Awaiting feedback from the institution

In August 2023, the NPM received information about the follow-up of our recommendations to Haraldsplass Serio Ung. Serio referred to various measures, such as training of staff and institution heads, adjustments to the work rota to better facilitate the recruitment of activity therapists and changes in written procedures to prevent abuse and avoid humiliating body searches. In some areas, such as the use of physical force and the prevention of social isolation, we needed more specific information on how our recommendations were implemented in practice. Therefore, the NPM asked for clarification from Serio both in October and December 2023. By the end of the year, we still needed further clarification on how the children at the institution safely can notify the proper authorities of potential abuse. We therefore asked Haraldsplass Serio Ung to report back on this issue by February 2024.

Visit 74: Den skreddersydde enhet (DSE), Agder (child welfare institutions)

Visit conducted: February 2023
Report published: June 2023
Status 31.12.2023: Case closed in December 2023

In October 2023, we received a follow-up letter from DSE informing us of several measures that had been implemented due to our recommendations. Among other things, DSE had worked to find a uniform method for the use of invasive physical force, and they had implemented measures to improve the quality of documentation on the use of force. DSE had also made changes to its document templates to ensure that continuous assessments are made on whether solo living is in the child's best interest, and a dedicated notification procedure for violence and abuse had been developed. We asked for copies of the new templates and procedures, and in December we closed our dialogue with DSE.

Visit 75: Bredtveit Prison and Ullersmo Prison (dept. Zulu Øst)

Visit conducted: March 2023
Report published: June 2023
Status 31.12.2023: Awaiting feedback from the institution

This visit was originally not part of the NPM visiting plan for 2023. We had, for some time, received concerning reports about the conditions at the prison. When several female inmates at Bredtveit were urgently moved to a section at Ullersmo Men's Prison, we decided to adjust our plans for the spring and undertake a completely unannounced visit to the prison.

Our visit uncovered critical and life-threatening conditions, such as the use of extensive solitary confinement, widespread and serious failings in the prevention of suicide and self-harm, critical shortcomings in staffing and leadership and significant weaknesses in the health services provided to inmates. The severity of this situation led us to issue an urgent notification to the Ministry of Justice and Public Security, informing about the critical and life-threatening conditions at the prison on 23 March 2023, one week after our visit. This was the first such notification issued since the NPM was established in 2014. For more information on this visit, see the article on page 24.

The prison submitted its first feedback report in October, and the NPM assessed that the report did not provide sufficient information on the measures that had been implemented after our visit. The NPM has therefore requested additional information and documentation to better assess the prison's follow-up of our recommendations.

The Bjerke District's healthcare department gave a brief response to our recommendations. The NPM deemed the district's response inadequate, as several of our specific recommendations were not addressed in the district's response. As such, we requested additional information to assess the measures that have been implemented.

In December, we learned that Bredtveit Prison will be closed in 2024 due to inadequate fire safety. This will impact our further follow-up of the visit report. In the coming year, we will closely monitor any temporary solutions for Bredtveit Prison and work to establish a new prison for female inmates in the Oslo region.

Bredtveit Prison.
Photo: Parliamentary Ombud/NPM

Visit 76: Holding cells at Oslo District Court

Visit conducted: September 2023
Status 31.12.2023: Report being prepared, to be published in 2024

Visit 77: Halden Prison

Visit conducted: October 2023
Status 31.12.2023: Report being prepared, to be published in 2024

Visit 78: Agder Prison, Froland Unit

Visit conducted: November 2023
Status 31.12.2023: Report being prepared, to be published in 2024

Visit 79: Bodø Prison

Visit conducted: November 2023
Status 31.12.2023: Report being prepared, to be published in 2024

Follow-up of previous visits

An important component of the NPM's work occurs after the visit reports have been published.

All the places we visit must 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 close the case. In 2023, we followed up three visits from 2022. These were processes that had not been completed at the end of 2022.

Visit 68: Housing for persons with developmental disabilities in the Municipality of Bodø

Visit conducted: April 2022
Report published: September 2022
Status per 31.12.2023: Case closed with County Governor in January 2023 – Case closed with the municipality in February 2023

In April 2022, the NPM visited six people with intellectual disabilities across three institutions in the Municipality of Bodø. The visits uncovered weaknesses in the municipality's and the County Governor's decision to use coercive measures, combined with disorganisation and delays in the approval of decisions. This led to several residents in the municipality being subjected to coercive measures without a valid decision for extended periods, some for more than a year. In addition, the NPM found that challenging living conditions and staffing problems led to an increased risk of coercion.

The risk was especially high for one resident who was locked in around the clock, a practice that the Health and Care Services Act does not permit. It was highly censurable that the illegal deprivation of freedom was not uncovered in the County Governor's regular review of the case. We also found weaknesses in the municipality's efforts to monitor and follow up on the residents' health. The Municipality of Bodø and the County Governor of Nordland responded to our recommendations in January 2023.

The municipality's response indicates that it has worked hard to follow up on the NPM's recommendations. The municipal leadership has been informed of the report and has also visited the institutions in question. Several measures were implemented based on the visit report, including meetings to ensure that decisions to use coercive measures are legally compliant and a reinforcement of the municipal resource group for coercion and force. Agreements will be established between the municipality and responsible supervisors in the specialist health services for each individual case where force and coercion are used in accordance with Chapter 9 of the Health and Care Services Act. This is done to ensure continuous assessment of decisions to use coercion.

As for the resident who was locked in around the clock, the municipality has implemented several measures to end this illegal practice. The case raises several ethical and practical challenges for the municipality, and both the County Governor and the specialist health services have provided guidance in the case. The institution's professional competence and on-site leadership have been reinforced, and a plan has been developed to give the resident increased self-determination in connection with the locking of doors and windows. The municipality is also considering alternative housing options to meet the resident's needs in the long term, in consultation with the next of kin and the legal guardian. Considering the municipality's response, the NPM decided to close the case in February 2023.

The County Governor of Nordland also received recommendations in the wake of the NPM visit. In February of 2023, we received feedback on how the County Governor is following up on our recommendations. New procedures have been developed for the regular review of decisions, in order to prevent delays. A new template for legal review has also been created, reflecting the NPM's recommendation. The County Governor has also recruited additional employees with particular expertise on developmental disabilities and the use of coercion and force. There are also plans to increase the frequency of on-site supervisory visits. The NPM completed its follow-up with the County Governor in February 2023.

City of Bodø. Photo: Parliamentary Ombud/NPM

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"When the Parliamentary Ombud concludes that our services are illegal, the Municipality of Bodø will, of course, take action. The unit has prepared an action plan with various measures to ensure faciliated services with no illegal deprivation of freedom." [1]

(the Municipality of Bodø)

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"The County Governor of Nordland […] has, in its improvement activities this autumn, actively implemented the findings and recommendations from the visit report to ensure legal protection of persons with developmental disabilities." [2]

(the County Governor of Nordland)

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1 Letter from the Municipality of Bodø to the NPM, 31.01.2023. Unofficial translation by the NPM.
2 Letter from the County Governor of Nordland, to the NPM 17.01.2023. Unofficial translation by the NPM.

Visit 69: Regional Secure Psychiatric Unit, Oslo University Hospital, Dikemark.

Visit conducted: August 2022
Report published: January 2023
Status 31.12.2023: Awaiting feedback from the institution

During the NPM's visit to the regional secure psychiatric unit at Dikemark, we found that unsuitable and undignified physical conditions led to an increased risk of coercion. We met several patients who had experienced extensive restrictions and use of force due to building-related issues. Loose cables, pipes and bricks caused dangerous situations in the unit. Long, narrow stairwells also posed a safety risk and impeded patient access to outdoor areas and fresh air. Several of the patient rooms did not have a bathroom or toilet. The patients are severely ill and often admitted for extended periods, some for many years. Some patients were subjected to restraints and segregation for many months on end. We found a lack of documentation of whether the use of restraints continued to be "absolutely necessary" for the entire period. Overall, the NPM believes there was a clear risk of inhuman and degrading treatment in the institution.

Regional secure psychiatric unit, Oslo University Hospital, Dikemark.
Photo: Parliamentary Ombud/NPM

In April 2023, the NPM received a response to our recommendations from Oslo University Hospital. The hospital describes having initiated in-house training on the use of force, prepared a template in the medical records system to comply with documentation requirements and revised internal instructions for communication with the outside world. Furthermore, the hospital has implemented several measures to inform the patients about their rights and appeal options. Part of the response from the hospital was very general, and we, therefore, requested a more detailed description of how our recommendations concerning physical conditions and prevention of extended use of restraints and segregation were being followed up.

In its second response to the NPM, in August 2023, Oslo University Hospital provided information on their work to prevent extended and extensive use of coercion. The hospital pointed to several important measures, but the NPM also deemed this response inadequate. Specific issues, such as the failure to document the continuous assessment of whether restraints are "absolutely necessary", were not addressed in the response. As a result, we again requested a more detailed description of measures and changes.

In the response from August 2023, the NPM was also informed that Oslo University Hospital had allocated NOK 3.9 million for building maintenance. This is very positive and in line with the NPM's recommendations for the maintenance of existing buildings to establish satisfactory conditions for patients while waiting for a new building to be built. The new building will be ready in late 2026. We have requested a status update on the maintenance work in April 2024.

Supervisory commission activities

Our visit also covered the activities of the supervisory commission for Dikemark. We found that the supervisory commission, which met at Dikemark every 14 days, was active and thorough, and contributed to greater legal protection for the patients. The supervisory commission was also found to promote awareness of the legal framework and how to prevent the use of force among staff. As such, the report did not include any recommendations for the supervisory commission.

Visit 70: Regional Secure Psychiatric Unit, St. Olav's Hospital, Østmarka

Visit conducted: September 2022
Report published: February 2023
Status as of 31.12.2023: Awaiting feedback from the institution and supervisory committee.

During our visit to St. Olav's Hospital, Østmarka, we found, among other things, that decisions regarding the use of force varied considerably in quality and that it, in some cases, was difficult to determine whether the statutory requirements for the use of restraints had been met. We also found examples where no continuous assessment of whether restraints were "absolutely necessary" had been made. The review of decisions and records where restraints had been used gave rise to concerns of a problematic normalisation of the use of restraints, especially transport restraints. Furthermore, the institution had strict and detailed house rules, and several of the rules severely limited the patients' right to self-determination without this being sufficiently justified by security considerations. The institution also had a general ban on patients using their own mobile phones during their stay. The law does not permit such general prohibitions on the use of personal phones, and the institution seemed unaware of how invasive such a ban is for the individual patient.

From the regional secure pshyciatric unit, Østmarka. Photo: Parliamentary Ombud/NPM

In its response to the NPM in May 2023, the hospital stated that it had developed an action plan to follow up on the recommendations from the report at various levels of the organisation, with status updates to clinic management three times per year. The hospital described several measures, such as random reviews, in-house training and weekly reviews of new decisions concerning the use of force, to accommodate the NPM's recommendations. It is positive that some of the measures implemented in response to our visit report are also being implemented for other mental health units at St. Olav's Hospital. This shows that our recommendations can have ripple effects beyond the individual units that we visit.

As for the ban on personal phones, the hospital maintained its position that all patients must surrender their phone upon admittance but that they, by individual agreement, could be permitted to use it. In this instance, the NPM's recommendations were not accepted. We therefore requested that the hospital provide new feedback on how they ensure patients have access to their personal phones in accordance with the Mental Health Care Act.

Supervisory Commission activities
Our visit also covered the activities of the Supervisory Commission for Østmarka. The supervisory commission had assessed the unit's ban on personal phones and concluded that the law permits such a general ban on personal phones in house rules. The NPM finds it very concerning that the commission did not make a more thorough examination of the law regarding this issue. We also pointed out that the commission had organised its activities in such a way that it risked a lack of continuity and unsatisfactory information-sharing within the commission.

The supervisory commission's response to the NPM in May 2023 contained very little information on how the commission is following up on the recommendations that concern them, and the NPM has, therefore, requested a new response.

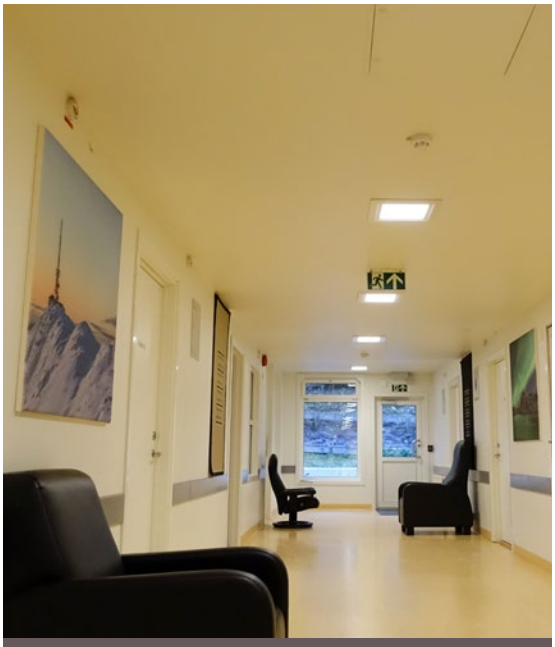
Visit 71: Regional Secure Psychiatric Unit, Haukeland University Hospital, Bergen Health Trust

Visit conducted: December 2022
Report published: May 2023
Status as of 31.12.2023: Case closed with the Supervisory Commission in October 2023 and case closed with Bergen Health Trust in December 2023

During our visit to Bergen, we also found examples where the justification for the use of restraints did not meet the requirement for such use to be "absolutely necessary". In some of these decisions, the prevention of potential future incidents was given as the justification for the use of restraint, and we found cases where it was not clear whether less invasive measures had been considered to manage the situation. We also found examples of a patient having their contact with the outside world restricted for an extended period, seemingly without any actual, specific and individual assessment. Furthermore, we found unsatisfactory guidelines and uncertainty among staff about how routine body searches should be conducted and when more invasive examinations required a formal decision. This

increased the risk of more invasive measures than the law permits. During the visit, it was also revealed that strip searches were conducted in the visitation room. This was a room designed for visitors, which also served as a thoroughfare from the entrance area and which contained several different doors and windows. The NPM pointed out that such a room is not suitable for establishing the type of safe atmosphere required for the intimate and potentially invasive situation of a body- or strip search.

The response from the hospital in September 2023 states that the visit report from the NPM was addressed at different levels within the hospital. The hospital points to a need to establish more uniform procedures and systematic control and follow-up of the use of force at all levels. Among other things, a training programme will be developed on the legislative framework and the use of coercion. This training will be offered to both new and current employees. In addition, a monthly list of decisions on the use of force will be prepared, and these lists will be made available to all relevant employees. A revised procedure for body searches and the establishment of a dedicated reception room are also being prepared. After some communication with the institution in the autumn of 2023, we decided to complete the follow-up process in December 2023.



From the visit to Regional Secure Psychiatric Unit Bergen. Photo: Parliamentary Ombud/NPM

Supervisory Commission activities

The Supervisory Commission also informed the NPM about its follow-up on the report's recommendations. It seems the commission has assumed an active role vis-à-vis the hospital in its follow-up work, which the NPM deems to be a positive development. The commission states that it will follow up on the hospital's decisions even more closely in the future. The NPM closed its dialogue with the Supervisory Commission in October 2023.

Advisory, Educational, and Cooperation Function

Outreach and communication activities are a key part of the effort to prevent torture and inhuman treatment. In 2023, we met with national authorities, responded to consultations, and spoke at relevant conferences. Below we present some highlights from the past year.

The Advisory committee

The Advisory Committee shall contribute with expertise, information, advice, and input to the NPM.[3] In 2023, a new mandate for the committee came into force. The new mandate clarifies the role of the committee, the duration of appointments and distinguishes between individual members and members who represent selected organisations.

In 2023, we held three meetings with the committee, discussing findings from visits to child welfare institutions, secure psychiatric units at the regional level, and the conditions at Bredtveit Prison. The NPM has also met several individual committee members and organisations separately, to gather information about the conditions in various prisons. This information has been valuable and has helped determine relevant prisons for future visits.

From the meeting with the advisory committee on 12 June 2023. Photo: Parliamentary Ombud/NPM

3 Section 19 of the Parliamentary Ombud Act specifies that the Parliamentary Ombud shall have a specific advisory committee for his or her work as a national preventive mechanism.

Members of the Advisory Committee 2023:

- **Amnesty International Norway**
- **Equality and Anti-Discrimination Ombud**
- **Human Rights Committee of the Norwegian Medical Association**
- **Human Rights Committee of the Norwegian Psychological Association**
- **Jussbuss (free legal aid clinic run by law students)**
- **Norwegian Alliance for Informal Carers**
- **Norwegian Association for Persons with Intellectual Disabilities (NFU)**
- **Norwegian Bar Association**
- **Norwegian National Human Rights Institution (NIM)**
- **Norwegian Red Cross**
- **The Ombudsperson for Children**
- **The Organisation for Families and Friends of Prisoners (FFP)**
- **WayBack**
- **We Shall Overcome National Association**
- **Youth Mental Health Norway**
- **Nora Sveaas**, Professor Emerita, University of Oslo, former member of the UN Committee against Torture (CAT) 2005–2013 and former member of the UN Subcommittee on the Prevention of Torture (SPT) 2014–2018.
- **Georg Høyer**, Professor Emeritus, University of Tromsø, member of the European Committee for the Prevention of Torture (CPT) 2012–2022.
- **Asbjørn Rachlew**, Police Superintendent and researcher, Norwegian Police University College and the Norwegian Centre for Human Rights, member of the European Committee on the Prevention of Torture (CPT) since 2022

Mental health care services

In the spring of 2023, the NPM published three reports from visits to secure psychiatric units at the regional level in 2022. For more information about our findings, see the separate article on page 31. In the autumn, we presented our findings at the annual seminar of SIFER, a national network focusing on security, prisons, and forensic psychiatry. In November, we also presented our findings at the yearly conference of supervisory commissions in mental health institutions. We also participated in the national reference group for developing a new plan for secure psychiatric units in Norway and other measures for persons sentenced to compulsory mental health care.

A committee was established by the government in 2023 to look at the care provided to persons with severe psychological disorders who have committed criminal offences. The NPM was invited to present our findings and recommendations shortly after the committee had been established.

Parliamentary Ombud Hanne Harlem presenting the main findings from the visit to Bredtveit Prison. Photo: Parliamentary Ombud/NPM

Panel at Amnesty's event during Arendalsuka in August 2023. From left: Ingrid Stolpestad (Amnesty), Heidi Bottolfs (KDI), Johan Lothe (WayBack) and Helga Fastrup Ervik (NPM Head). Photo: Parliamentary Ombud/NPM

Prisons

Several new prison visits in 2023 and our investigation into suicide prevention in prisons[4] served as the foundation for two public seminars, multiple meetings with the Directorate of Norwegian Correctional Service (KDI) and closer contact with relevant professional and research communities. As in previous years, we have lectured at the University College of Norwegian Correctional Service (KRUS). In addition, we also spoke at the KDI and KRUS digital women's conference in November and at the KDI workshop for legal staff in the correctional service.

We also presented our findings at a national network meeting organised by the Directorate of Health for municipal health services in prison. 123 healthcare professionals from 29 municipal prison health services attended the meeting. We were also invited by the Norwegian Correctional Service, Region West, to present our findings regarding health services in prison. In addition, we have participated in several discussions and panels concerning prison conditions organised, among others, by Amnesty International Norway.

We have also responded to several consultations about the carceral system in the past year. One of these concerns proposed amendments to the Execution of Sentences Act and the Health and Care Services Act as these relate to association, exclusion, and use of force in prison. This consultation from the Ministry of Justice is a clear follow-up of recommendations made in the NPM's special report to the Storting on solitary confinement (2019). In our consultation response, we point out that the proposed amendments entail several positive changes but that they do not sufficiently protect the fundamental rights of inmates. The rules must be more explicit to ensure inmates can associate with others and prevent long-term solitary confinement. We have also commented on the proposal for revised national guidelines on municipal health and care services for inmates and Official Norwegian Report 2023:5 on women's health and the impact of gender on health.

In 2023, we also looked closer at the system of publicly funded probational release to institutional care or municipal housing for persons sentenced to preventive detention.[5]

4 For more information, see the thematic article on page 22 in the NPM Annual Report 2022: https://www.sivilombudet.no/wp-content/uploads/2023/04/Annual_Report_2022_Norwegian_Parliamentary_Ombud_FN_web.pdf

5 See Section 45 (1) (c) of the Penal Code.

Presentation for the Human Rights Committee of the Norwegian Association of Judges

The Norwegian Association of Judges has developed a guide on solitary confinement to aid judges in remand hearings and promote awareness of the harmful effects of solitary confinement, international commitments, and recommendations. The NPM participated in a panel debate when the guide was launched on 12 October 2023.

From the launch of the Solitary Confinement Guide.
From left: Thom Arne Hellerslia (Supreme Court Justice), Helga Fastrup Ervik (Head of National Preventive Mechanism), Philip Green (Police Prosecutor) and Maria Hessen Jacobsen (lawyer).
Photo: Parliamentary Ombud/NPM

Child welfare institutions

In 2023, the NPM conducted eleven visits to children living alone with adults in a child welfare institution. Before these visits, we met with the Director of the Directorate for Children, Youth and Family Affairs (Bufdir) to inform her of our previous findings and plans for the year.

Our visits highlighted two weaknesses in child welfare legislation, the first concerning children who live alone. For some children, living alone with adults can be a good solution. However, such an arrangement may lead to a risk of social isolation. Therefore, authorities should consider the need for specific rules to ensure regular assessment of whether it is in the child's best interests to live in this way on their own. Secondly, our visits highlight the risks of inadequate regulation of invasive restraint techniques in the child welfare system. Being restrained is a type of force that should be strictly regulated.

Director of the Directorate for Children, Youth and Family Affairs (Bufdir) Hege Nilssen and Parliamentary Ombud Hanne Harlem.
Photo: Parliamentary Ombud/NPM

Insecurity, lack of training, and lack of regulatory clarity on restraint techniques increase the risk of violations against children in child welfare services. This was also communicated to the Minister of Children and Families at a meeting about the use of force in child welfare services in June 2023.

The Police Immigration Detention Centre at Trandum

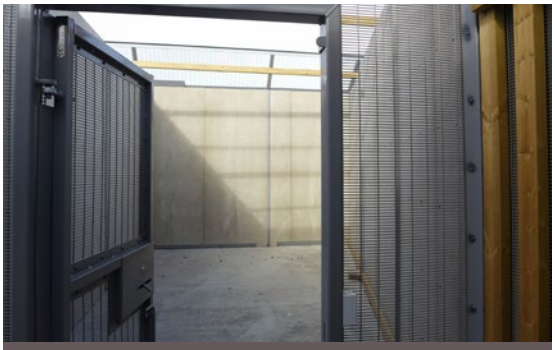
For years now, the NPM has expressed concern about the conditions for detainees at the Police Immigration Detention Centre at Trandum. We see a clear need for changes at the institution. This includes the current practices relating to locking detainees in their cells, which the NPM deems to be illegal. We also cannot see that the Immigration Act allows the authorities to take mobile phones away from the detainees, which is also a current practice at the centre. The Supervisory Board for the Detention Centre has also, over time, expressed similar concerns.

New system for detainee health services

The Storting asked the government to transfer health services to immigration detainees from a private contractor to public health services no later than 1 July 2023.[6] In the autumn of 2023, the NPM responded to a consultation from the Ministry of Health and Care Services regarding this topic. We support the transfer of responsibility to the public health services. Still, we are critical that the proposed amendments to the Immigration Regulations seem to reduce the detainees' health-related rights. When the state deprives a person of liberty, it has a greater responsibility to protect the detainee's life and health. This should be reflected in the legal framework for the Immigration Detention Centre.

Written brief to Borgarting Court of Appeal

In 2023, the NPM prepared a written brief for clarification of broad public interests[7] (amicus curiae) in a civil case concerning conditions at the Police Immigration Detention Centre being heard by the Borgarting Court of Appeal in the autumn of 2023. This brief summarised the NPM's many statements and reports on the immigration detention centre in a format easily accessible to the court. In late October, the court concluded that the routine body searches and lockdowns in the case constituted a violation of Art. 3 and 8 of the European Convention on Human Rights. The court judgement was not final as of December 2023.



From the NPM's visit to the Police Immigration Detention Centre in 2017
Photo: Parliamentary Ombud/NPM

Revision of the Immigration Detention Regulation

For many years, the Ministry of Justice and Public Security has informed the NPM that they are working on revising the Immigration Detention Regulations. Proposed amendments to the regulations were sent to the Ministry from the National Police Directorate on 28 May 2021. The Ministry informed the NPM that it was working on the proposed amendment in the autumn of 2021.[8] In March 2022, the Ministry apologised for the delay.[9] In August 2023, the Ministry stated that proposed amendments to the Immigration Act and the Immigration Detention Regulation would be sent out for consultation around the end of the year.[10]

6 See decision no. 831, 17 June 2022, ref. The Storting's hearing of Meld. St. 2 (2021–2022) Revised National Budget 2022.
7 See Section 15-8 of the Dispute Act
8 See letter from the Ministry of Justice and Public Security to the NPM dated 23.08.2021
9 See letter from the Ministry of Justice and Public Security to the NPM, dated 15.03.2022
10 See letter from the Ministry of Justice and Public Security to the NPM, dated 12.09.2023

Unfortunately, this revision of the Immigration Detention Regulations has taken several years. There is a great need for changes in how the immigration detention centre is run, to ensure that the treatment of detainees is in line with Norway's human rights commitments.

Nursing homes and housing for persons with developmental disabilities

In 2023, the NPM continued to provide information about our findings from previous visits to these two sectors.

We are glad that the challenges we have observed are being addressed locally. The NPM's work in this field was part of why Oslo Municipality decided to map compulsory health care in the capital's nursing homes. This work was undertaken by the Norwegian National Centre for Ageing and Health and the Centre for Medical Ethics at the University of Oslo. The report was presented in June 2023, and the NPM participated and presented our national findings here as well. Putting the use of force in nursing homes on the municipal agenda could help raise awareness of the applicable regulations and reduce the risk of unauthorised use of force against elderly people in institutions.

At the beginning of the year, we presented our findings from visits to homes for persons with intellectual disabilities to Supervisory Officers at the state and county levels and Chief County Medical Officers at a conference organised by the Norwegian Board of Health Supervision's supervisory meeting. In the autumn, we lectured on our findings to learning disability nursing students at Østfold University College.

Custody

In 2021, the NPM investigated the conditions for children in Oslo Police Custody. This investigation also uncovered some nationwide issues, such as weaknesses in the documentation of the custody conditions for minors, children not being provided with tailored information about their rights and authorities lacking a reliable national oversight of the number of children in custody. We communicated our recommendations on these issues to the Ministry of Justice and Public Security in December 2021.

National guidelines have now been prepared for police encounters with children and interviews with children and other vulnerable groups when they are suspected of having committed a criminal offence. As for the preparation of uniform and national information material for minors in police custody, we were informed by authorities in the autumn of 2023 that this work had not yet been started and that it could take more than a year before this material was ready.[11] This is unacceptable. Every year, several hundred minors are detained in custody. This especially vulnerable group is entitled to correct and specifically tailored information about their rights while deprived of their freedom. In response, we requested an expedited process in a separate letter to the Ministry of Justice and Public Security. As a result, the National Police Directorate has now prepared preliminary national informational material for minors in custody. This material is to be made available to all police districts starting 1 December 2023.

From our visit to Oslo Central Custody Centre in 2021. Photo: Parliamentary Ombud/NPM

11 See letter from the National Police Directorate to the Parliamentary Ombud, 13 September 2023

International cooperation

93 states have ratified the UN Optional Protocol to the Convention against Torture (OPCAT), and there are 78 national preventive mechanisms globally. Sharing experiences and dialogue across countries inspires us, enhances our competence, and helps develop our work.

In the past year, we have initiated dialogue with other NPMs and been contacted to contribute to the work of others. We have greatly enjoyed sharing experiences with the UK NPM, and His Majesty's Inspectorate of Prisons for England and Wales (HMIP), on concerns regarding female inmates. This was useful to our work on Bredtveit Prison. Furthermore, we have had digital meetings with representatives of the Dutch and Armenian NPMs and representatives from Australia.

We also hosted a digital meeting of the Nordic network for NPMs in the spring, where we presented findings from our report on suicide in prisons. Furthermore, we participated in a meeting of the Nordic network hosted by the Swedish Parliamentary Ombudsmen, where we, among other things, discussed the conditions for children and young people in prison and how to ensure that our preventive activities remain effective.

The annual conference for human rights organisations and NPMs, organised by the The OSCE Office for Democratic Institutions and Human Rights (OSCE/ODIHR), the Association for the Prevention of Torture (APT) and the Danish Parliamentary Ombudsman was also a useful arena in which we participated actively. The 2023 conference focused on risk factors in the detainment of mentally ill persons.

The Nordic Network for National Preventive Mechanisms in Stockholm, September 2023
Photo: Swedish Parliamentary Ombudsmen

Visit to Bredtveit Prison

During 13–16 March 2023, the NPM 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 emergency transfer of female inmates to Ullersmo Men's Prison in January 2023. A week after this visit, we issued an urgent notification to the Ministry of Justice and Public Security on critical and life-threatening conditions at the prison. This was the first such notice since the NPM's establishment in 2014.

Data collection and analysis

When we arrived at Bredtveit Prison on 13 March 2023, at approximately noon, we were informed that there had been a suicide at the prison two days before, on 11 March. We then obtained the prison's assessment of the situation and information about their plans for the following days. Based on this, we made our own assessment on whether it would be appropriate to continue the visit as planned, and how to adjust to the special operational needs that follow in the wake of a suicide. Taking this into account, as well as the NPM mandate and the high level of risk, which was the background for our visit, we decided not to cancel or postpone the visit. The prison management was informed of our decision and the basis for it approximately one hour after we arrived at the prison. We also made it clear that we would adjust our presence and data collection to the difficult situation that the prison and the inmates found themselves in.

We inspected the cells, common areas, security cells and some of the outdoor areas. Part of our team left to visit Ullersmo Prison, department Zulu-Øst, which, at the time of our visit, housed female inmates who had been urgently moved there in January because Bredtveit could not ensure their health and safety. Many of these women were struggling with severe mental health challenges.

From a prison corridor at Bredtveit prison.
Photo: Parliamentary Ombud/NPM

Due to the extraordinary situation at Bredtveit Prison during the time of our visit, we decided to conduct several of the interviews also in the weeks following the physical visit. In total, we conducted more than 50 in-depth interviews with inmates, correctional

officers, prison management, the municipal prison health service (primary health care services) and the prison psychiatric services (secondary health care services). We also collected and reviewed a large number of documents following the visit, including procedures, decisions, registers, logs, and records from both the correctional and the health systems. Our final analysis was presented in the NPM visit report from Bredtveit Prison and Ullersmo Prison, department Zulu-Øst.

Illegal use of extensive solitary confinement

Solitary confinement can harm the health of inmates even after a short period of time, and the adverse health effects can linger long after the solitary confinement has ended. Inmates who are young, suffer from mental health problems or have developmental disabilities are particularly vulnerable to the negative effects of solitary confinement.

During 2018–2022, Bredtveit prison registered a doubling of inmates being placed in solitary confinement in their own cell (excluded from associating with other inmates), from 36 inmates in 2018 to 77 inmates in 2022. At the same time, 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 in Norway (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. Water and food items are pushed in through a hatch at floor level, and there are no washing facilities in the cell. Most communication between the inmate and staff occurs through small hatches or plexiglass. While in a security cell, inmates are deprived of virtually all control over their own lives, to a far greater extent than the general deprivation that follows from imprisonment.

Most of the decisions concerning confinement in security cells that we reviewed did not fulfil the applicable statutory requirements. Many sequences of events indicated that prison staff had not done enough to prevent conflict, threats or violent acts that could have been foreseen. Examples include

From a security cell at Bredtveit prison. The picture was taken during the NPM's visit in 2016. Photo: Parliamentary Ombud/NPM

stress and worry in connection with impending court hearings or frustration over inactivity and a lack of association with other inmates, which led to further escalation, which was then dealt with by placing the inmate in a security cell. In many cases, the inmate was carried in handcuffs from the third floor to the security wing, which forms a ground-floor extension.

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, we found no explanation in the documentation as to why an inmate needed to remain in the security cell.

We found virtually no documentation indicating that inmates 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 of 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. A dedicated resource team at the prison 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.

The visit and subsequent review of documentation revealed that the prison failed to comply with the requirement that solitary confinement be used only 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 Eastern Regional Office, which is responsible for executing sentences at Bredtveit, also appears to have failed to identify these shortcomings.

Restraint bed at Bredtveit Prison.
Photo: Parliamentary Ombud/NPM

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 systems in place for identifying and following up the risk of self-harm and suicide, neither upon admission nor while inmates were serving their sentence. When we asked to see the prison's action plans for the prevention of suicide and self-harm for the period January 2022 to March 2023, we were given only one single plan.

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 mainly dealt with self-harm and indications of suicide risk through 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 made to address concerns about self-harm and suicide risk.

The prison's use of the restraint bed increased from two cases in 2018 to 26 cases in 2022. The use of solitary confinement and intrusive coercion towards inmates in crisis can reduce the likelihood that

A prison cell at Bredtveit.
Photo: Parliamentary Ombud/NPM

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 inmates suffering from severe mental health challenges than was previously the case. The prison consistently referred to the municipal 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 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 appeared overall to be inadequate, unsystematic and not sufficiently evidence-based. This increased the risk of the prison not fulfilling its obligation to safeguard the inmates' right to life.

Documentation of prison conditions and medical follow-up of the inmate who, two days before our visit, had committed suicide, confirmed a need for change, both in the prison's suicide prevention activities and in the evaluation and learning process in the wake of a suicide. It was also revealed that the supervisory board for Bredtveit Prison had not been informed of the incident. Due to confidentiality, we did not describe our findings about this issue in detail in our visit report. Still, we shared our findings with the prison, the municipal healthcare department and the prison's psychiatric outpatient clinic.

Difficult prison conditions

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

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 to security-cell placements.

The staff's perception of stress, powerlessness and time pressure increased the risk of disproportionate use of force. 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. We found incidents where the use of considerable physical force had resulted in inmate injury, and one inmate was deprived of their

Reinforced cell at Bredtveit Prison
Photo: Parliamentary Ombud/NPM

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 encountered by the NPM appeared to be directly caused by weaknesses in staffing and leadership at the prison.

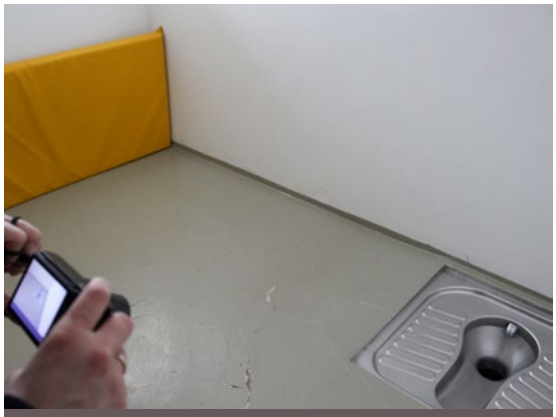
Staffing levels at the prison were so low that any unplanned absence had serious consequences for the prison day-to-day operations and, therefore, directly impacted the inmates. It was clear that staffing challenges led to cancelled rehabilitation measures such as activities, access to fresh air, and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

In many crucial areas, no procedures or systems were 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 ensuing use of coercion. Conversations with staff revealed considerable and extensive uncertainty concerning work relating to health, safety and environment and how operational errors and deviations were followed up. There were also no procedures in place providing 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 placements in pre-trial detention or admission to the mental health service.

Significant weaknesses in health services provided for inmates

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 each other. 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



Visit to the security cell in Bredtveit Prison
Photo: Parliamentary Ombud/NPM

Health services in Norwegian prisons
In Norway, the municipal authorities run the prison health service as the primary health care provider, or inmates. This is known as 'the import model', where the health services are independent of the Correctional Service. The model ensures the medical personnel's independence of the Correctional Service. The import model is also intended to ensure that medical personnel never partake in administrative decisions on sanctions, or in enforcing sanctions.

challenge. The management of the two healthcare services and the prison did not hold regular meetings with each other, and we found no evidence of any general collaboration aimed at improving the health situation of 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 solitary confinement was used as a response to suicide risk. We found no systematic recording of injuries suffered by inmates while they were in solitary confinement. The department also lacked supervision procedures concerning exclusion and the use of security cells. There was no evidence to suggest that they carried 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 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 services 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 been 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 critical 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 moved to Ullersmo Prison

The NPM is critical of the decision to transfer female inmates to the Zulu East solitary confinement wing at Ullersmo men's Prison on 27 January 2023. The women were placed in a prison department 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 in a men's prison did not make it possible to end the exclusion.

We are also highly critical to the fact 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 locked to avoid male and female inmate interaction. It was not possible for the female inmates to use the gym room or the prison yard without encountering male inmates.

Government response

A number of changes were implemented shortly after our urgent notification was issued to the Ministry of Justice and Public Security and before the report was completed and published. Among other things, the women who had been moved to a unit at Ullersmo Prison were soon moved again, a detailed action plan was prepared and implemented at Bredtveit prison to address several of the shortcomings we had pointed at, the director of Bredtveit Prison resigned, and the number of inmates at Bredtveit Prison was reduced when Skien Prison was opened as a women's prison on 5 June 2023.

Our visit report was published on 20 June 2023, and the NPM held a public seminar on this date, where we presented the main findings of our report. The presentation was streamed, with hundreds of users watching from across the country. Participants represented both decision-makers and operational staff, supervisory bodies, prison officers, and health personnel. The video from the event is available online. Our report included 43 recommendations to four different entities: Bredtveit Prison, the Norwegian Correctional Service Region East, Bjerke District (primary health care provider) and the prison psychiatric outpatient service (secondary health care provider).

Visits to three regional secure psychiatric units

Regional secure psychiatric units have the highest level of security in the mental health services. These units have higher staffing levels and special statutory provisions for security measures. The units shall have specialised expertise in high-security psychiatry and work closely with regional centres of expertise in high-security, prison and forensic psychiatry.

Those admitted to such units have or are being evaluated for, severe mental illness combined with a high risk of violence. According to the Mental Health Care Act, regional secure units accept patients where enhanced security measures are necessary due to a particular risk of escape, hostage-taking, severe violence or attacks against the patient themselves, other patients, or personnel.[1]

Most patients in an RSA have been compulsorily admitted and may be made subject to further coercive measures during their admittance. Many are admitted over extended periods, some for several years. The high level of security means that the patient's ability to make their own choices and control their everyday lives is severely limited. They largely depend on staff to meet their daily needs.

In addition, the patients often have few family members with whom they are in contact. This is a group of patients with few people to speak on their behalf, and limited interest from the media.

Some patients may find it difficult to transfer to a lower treatment and security level after being deemed ready for discharge from the regional secure units. If people who are ready to be discharged must remain in such units, this could lead to them being subjected to more coercion and greater intervention in their personal integrity than necessary and permitted by law.

Overall, these factors increase the risk that patients admitted to a regional secure unit suffer inhuman or degrading treatment. It is for this reason that the NPM has prioritised visits to these units.

In 2022 we visited regional secure units at Oslo University Hospital (Dikemark), St. Olav's Hospital (Østmarka) and Haukeland University Hospital (Bergen), as well as the three supervisory commissions that oversee these units.

Visit to regional secure unit, Bergen.
Photo: Parliamentary Ombud/NPM

1 Section 4A-2 (3) of the Mental Health Care Act.

The three institutions differed in several areas. Some differences can be attributed to variations in building structures, whereas others were caused by variations in local practices, which resulted in different house rules for the patients. Below are some of our main findings from the three visits.

Physical conditions

All mental health care institutions must be designed and equipped to meet the requirement for sound health services. The physical conditions must meet the patient's need for treatment and care and must ensure a positive therapeutic environment.

For some time, it has been known that the Dikemark building is in critical condition. Our visit confirmed this. We saw that the physical conditions clearly affected the use of force negatively and were intrinsically degrading. The building appeared to be very unfit for the patient group.

Sound travelled very easily through the building. Noise from other patients, alarms and employees created a disturbance, which, in some cases, led to the use of force. Rooms, corridors, communal areas, and stairwells were narrow and poorly lit, creating dangerous situations for patients and employees. This also made it difficult for the patients to go outside, get fresh air and exercise, activities that can be preventive in themselves. Brick walls were crumbling, and stone, pipes and cables could easily be pulled loose and used to cause self-harm or harm to others. Rooms with restraint beds were in the same corridor as patient rooms and other patients were able to see and hear if someone was placed in restraints.

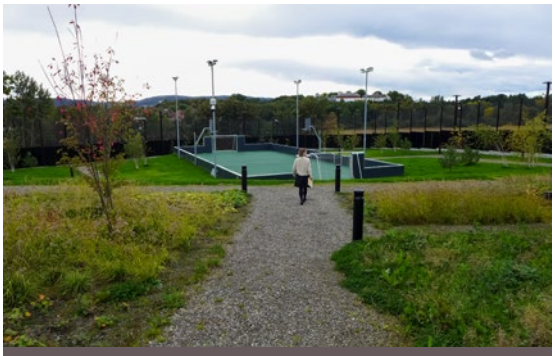
It was clear that the unsuitable buildings reduced the opportunities for positive and conflict-preventing interactions between staff and patients. On the contrary, the physical conditions contributed to the increased use of force and segregation. In addition to posing a high risk of inhuman and degrading treatment of patients at Dikemark, the conditions also raise questions concerning the right to equal treatment of patients admitted to such units in Norway.

There were also some problematic building issues at Bergen. Here, three of the patient rooms did not have a toilet. A large part of the outdoor area was not secured in a way that allowed all patients to use it. In addition, we discovered that a visitation room, with several access points, was used to strip-search patients.

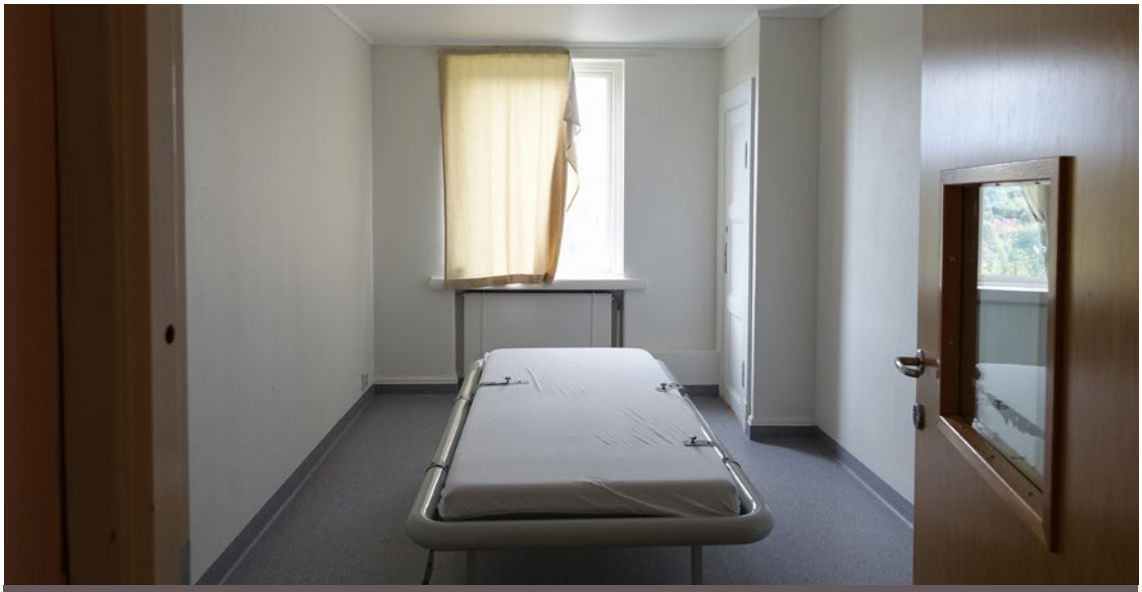
Use of force

Strict requirements must be met before force can be used in the mental health care services. Force can only be used as a final resort to prevent imminent harm to the patient or others, and where other

Exercise yard at Dikemark
Photo: Parliamentary Ombud/NPM



Exercise yard at Østmarka
Photo: Parliamentary Ombud/NPM



Restraint bed at Dikemark. Photo: Parliamentary Ombud/NPM

measures clearly will not work or have proved ineffective. Force shall be applied as gently as possible and for as short a time as possible. Restraint beds and transport restraints are examples of coercive measures. In a restraint bed, the patient is placed on their back and restrained with belts attached to the bed. Transport restraints are customised belts worn by the patient, and allow a somewhat greater range of motion than a restraint bed.

Decision to use force

Most decisions to use restraints that we reviewed made an adequate case for the "absolute necessity" to use the restraint to prevent harm, as required by law. At all three units, however, we also found decisions to use restraints that were insufficiently justified. In some of these, the description of the situation before the use of restraints was not sufficient to determine whether the condition had been met. Examples include brief mentions of the "patient acting out". In several decisions, it was also unclear whether less invasive measures had been attempted before a decision to use restraints was made.

In order to protect the rights of patients subjected to the use of force, and to ensure the possibility of control, a detailed and precise description of events, as well as an explanation of why force was necessary and which types of force were used, must be documented. The more invasive the coercive measure, the greater the need for thorough and stringent justifications.

Extended use of restraints

Several patients were restrained for extended periods of time, some for days, weeks and even months. In many of these instances, it was not documented whether continuous assessments had been made to ensure that the restraint was "absolutely necessary" for the whole duration of the measure.[2] For example, one record had an entry on a Wednesday specifying that the patient would remain in restraints over the weekend. This clearly violates the requirements of the Mental Health Care Act. Restraint inspections, which should be performed every 8 hours, often did not include an assessment of whether restraint continued to be an "absolutely necessary" measure.

2 This is also a challenge identified by the Parliamentary Ombud in the report on the use of mechanical restraints in mental health care services (2022)

NPM Head Helga Fastrup Ervik examining a spit hood at Dikemark.
Photo: Parliamentary Ombud/NPM

review of decisions and records relating to the use of restraints for extended periods gave rise to concerns that these measures are not subject to an actual and continuous assessment. This was especially true of transport restraints. In some cases, transport restraints were used on patients who also were subjected to extended periods of segregation. In several of these cases, information about how staff worked to reduce the use of force was poorly documented. We also found a lack of documentation that patients were offered defusing conversations after restraints had been used. Such conversations and feedback from patients can be used to prevent future use of restraints.

Without systematic preventive work implemented over time, there is a risk that the use of invasive coercion is normalised in institutions. This, in turn, also increases the risk of force being used when it is not absolutely necessary.

At Dikemark and Østmarka, we found spit hoods that could be used on patients.[3] The law does not permit such use, and they were removed after our visit.

Segregation

When a decision to segregate has been made, the patient in question is entirely or partially cut off from associating with other patients and only has contact with health personnel.[4] This is done to reduce sensory input or as a security measure to protect others from aggressive behaviour.[5] Segregation may take place in a segregation unit or the patient's own room.

At Østmarka, staff had developed an internal guideline called “Personalised segregation”. This seemed to help ensure specific and continuous assessments of the need to segregate a patient.

At both Bergen and Dikemark units, segregation would take place in the patient's room when the segregation unit was occupied. This type of segregation can increase the risk of isolation, as staff usually must remain in the corridor while the patient is alone in his/her room. The negative consequence of such practice was most clearly observed at the Dikemark unit, where segregation in the patient’s own room was most frequently used. The rooms were small, and in practice, opportunities to go outside for exercise or have contact with staff were limited. Some patients were segregated under such conditions for many weeks and months.

House rules

The Mental Health Care Act allows mental health care institutions to implement house rules, but these cannot infringe on patients' fundamental rights and freedoms without a clear legal basis.

The right to free communication is such a right. It cannot be limited without a basis in law and a specific assessment of whether this is necessary and proportionate for the individual patient. If this right is to be limited, a decision must be made so that the patient has an opportunity to understand

3 A spit hood is a transparent hood pulled over a person's head and has a field covering the lower half of the face, preventing spit from exiting the hood.
4 Section 4-3 of the Mental Health Care Act
5 See also the Parliamentary Ombud report on Segregation in mental health care services (2018).

From the visit to regional secure unit in Bergen.
Photo: Parliamentary Ombud/NPM

the justification and appeal the decision. The right to free communication includes the use of a personal mobile phone.

The three units had completely different rules for the patients' access to their own personal phones. In Bergen, all patients normally had access to their personal phones and computers in their own rooms. At Dikemark, they implemented this same arrangement from July 2022 onwards, though with phones being stored in the staff room overnight. In Østmarka, however, house rules stipulated that no patients were allowed to use their personal phones while in the unit. The phones were kept in the staff room, and the patients could ask to check their calls and messages and use their phones for other purposes, but the main rule was that they were not allowed to send messages or make calls from their own personal phones.

At Østmarka, the house rules were strict, very detailed and written in an unfriendly tone. They were formulated as absolutes. Several rules severely limited the patient's right to self-determination without this being justified by security needs. Such rules can contribute to increased frustration, which can lead to conflicts and increased use of force. This risk was confirmed by a specific case where rigid enforcement of house rules strongly contributed to the escalation of a situation that ended up with the use of restraints.

Supervisory commissions and patient safety

Effective appeal and supervisory systems are important for protecting patient rights and preventing inhuman treatment. Supervisory commissions at all three units informed us that few patients or family members appealed to the commission. Therefore, they spent most of their time on document review and welfare checks.

The supervisory commission at Østmarka had established a system of two separate commissions, where one was led by the director and the other by the deputy director. The two commissions alternated their visits to the wards. This organisational structure entails a clear risk that information from and about patients is not shared or picked up on. It could also affect the patients' opportunities to become familiar with the commissions.

There was considerable variation in how actively the supervisory commissions contacted patients. As for the patients' opportunities to have private conversations, the supervisory commissions often accepted the hospital's assessment that hospital staff had to be present during conversations with the commission.

Security considerations must be made, both for the patient and for the commission members. However, we would have liked to see the commissions reflecting more independently on how they could introduce themselves to the patients and whether accommodations could be made for confidential conversations. The NPM has on several occasions, pointed out that the commissions should themselves initiate contact with patients directly and be available to them in the unit's common areas.

We found some shortcomings in the supervisory commissions' legal reviews. One example of this is that spit hoods were discovered at two of the institutions, despite the use of such hoods being banned from use in mental health care services. The supervisory commission at Østmarka had furthermore assessed the unit's ban on personal phones and concluded that the law permits such a general ban on personal phones in house rules. The NPM disagrees with this assessment and found it concerning that the commission had not thoroughly examined the law or contacted the Norwegian Directorate of Health, which is responsible for the interpretation of relevant law.

The supervisory commissions at Dikemark and Bergen were generally active and thorough and contributed to the protection of patients' rights.

Please see the three visit reports for more detailed information on each institution.

- Visit report 69: Oslo University Hospital, RSA Dikemark
- Visit report 70: St. Olav's Hospital, RSA Østmarka
- Visit report 71: Haukeland University Hospital, RSA Bergen

Secure psychiatric units at the regional level

Secure psychiatric units are the part of the mental health care services that evaluates and treats people with severe mental illness and a high risk of violent behaviour. There are secure psychiatric units at both the local and regional levels. Regional secure psychiatric units have the highest level of security and accept the most resource-demanding patients and patients with the most severe risk of violent behaviour.

Regional secure psychiatric units in Norway:

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

Regulatory framework: Admittance to a regional secure unit is regulated both by civil law and by criminal law. Regarding civil law, the Mental Health Care Act is applicable and its provisions on compulsory mental health care.[1] Regional secure units receive most of their patients from local secure units and acute psychiatric units. In addition, most of the patients discharged from regional secure units go to local secure units.

Under criminal law, a defendant may be deemed legally incompetent by the court and sentenced to compulsory mental health care.[2] Convicted patients take up a quarter of all regional secure unit beds and half of all beds in local secure psychiatric units. [3] In addition, a defendant may be admitted to a regional secure unit as a substitute for being held on remand in prison or to undergo a judicial observation in connection with the preparation of a forensic psychiatric report.[4] A person under judicial observation is not considered a patient and shall not receive any form of treatment for mental illness.

1 Compulsory observation is regulated by Section 3-2 of the Mental Health Care Act, and compulsory mental health care is regulated by Section 3-3.
2 Section 62 of the Penal Code.
3 "Sikkerhetspsykiatri i Norge 2019. En statusrapport" by SIFER South East (Regional research and education centre for high-security, prison and forensic psychology). Section 3.1.1.1
4 Sections 188 and 167 of the Criminal Procedure Act.

Visits to eleven child welfare institutions in Agder

In the spring of 2023, the NPM visited institutions where one child lived on their own with adult staff. Around 115 children and youth in Norway live this way.[1] Very few of these arrangements are the result of administrative decisions stipulating that the minor is not to live with other minors.

We visited eleven different homes where youth lived alone with adult staff. These were institutions run by private child welfare service providers. None of the youth we visited had received an administrative decision that they must live without peers.

Despite this, several of the minors had lived alone in an institution for extended periods, some for several years. For some children, living in this way can be a good solution, but there is some risk that they will become socially isolated from peers and other people outside the institution.

Overall, however, it seemed that the young people we met had opportunities to spend time with peers, access to means of communication and freedom of movement.

Below are some main recommendations from our visits:

› Low awareness on how to prevent violence and abuse

We found several examples where staff were not familiar with the institution's procedures for the prevention and management of violence and abuse and where this was rarely a topic of discussion amongst staff. There will always be some risk of violence and abuse in institutional settings. Considering this, the NPM believes it is essential that all institutions ensure that this topic is regularly put forward for staff reflection and discussion.

› Poor knowledge of coercive techniques and the need for better regulation

We encountered several situations where staff were unsure how to handle situations where a young person made threats or acted out. We found weaknesses in the staff's knowledge of physical restraint techniques, and this led to situations where young people had been restrained on the floor with pressure exerted on their upper body, limiting respiratory functions. This is unacceptable. The NPM sees a clear need for better regulation of invasive restraint techniques in child welfare legislation and has raised this issue with the Ministry of Children and Families.

› Lacking risk assessments

None of the children we visited had an administrative decision determining that they should live alone without peers. In several institutions we visited, we could not find any assessments by the institution or child welfare services on whether it was in the child's best interest to live this way. The child's own views on this living arrangement had also not been systematically explored or documented.

1 This figure is based on the NPM's own data collection from County Governors and the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) in the autumn of 2022 and spring of 2023.

Photo: Gustav Gullstrand on Unsplash

Our work in numbers

Total

17

completed visits under our preventive mandate in 2023

11 visits to child welfare institutions

5 visits to prisons

1 visit to police custody

110
Interviews with prison inmates

101
Interviews with prison employees

98
Review of decisions on the use of force in child welfare institutions

8
Interviews with children in child welfare institutions

49
Interviews with employees in child welfare institutions

Outreach activities

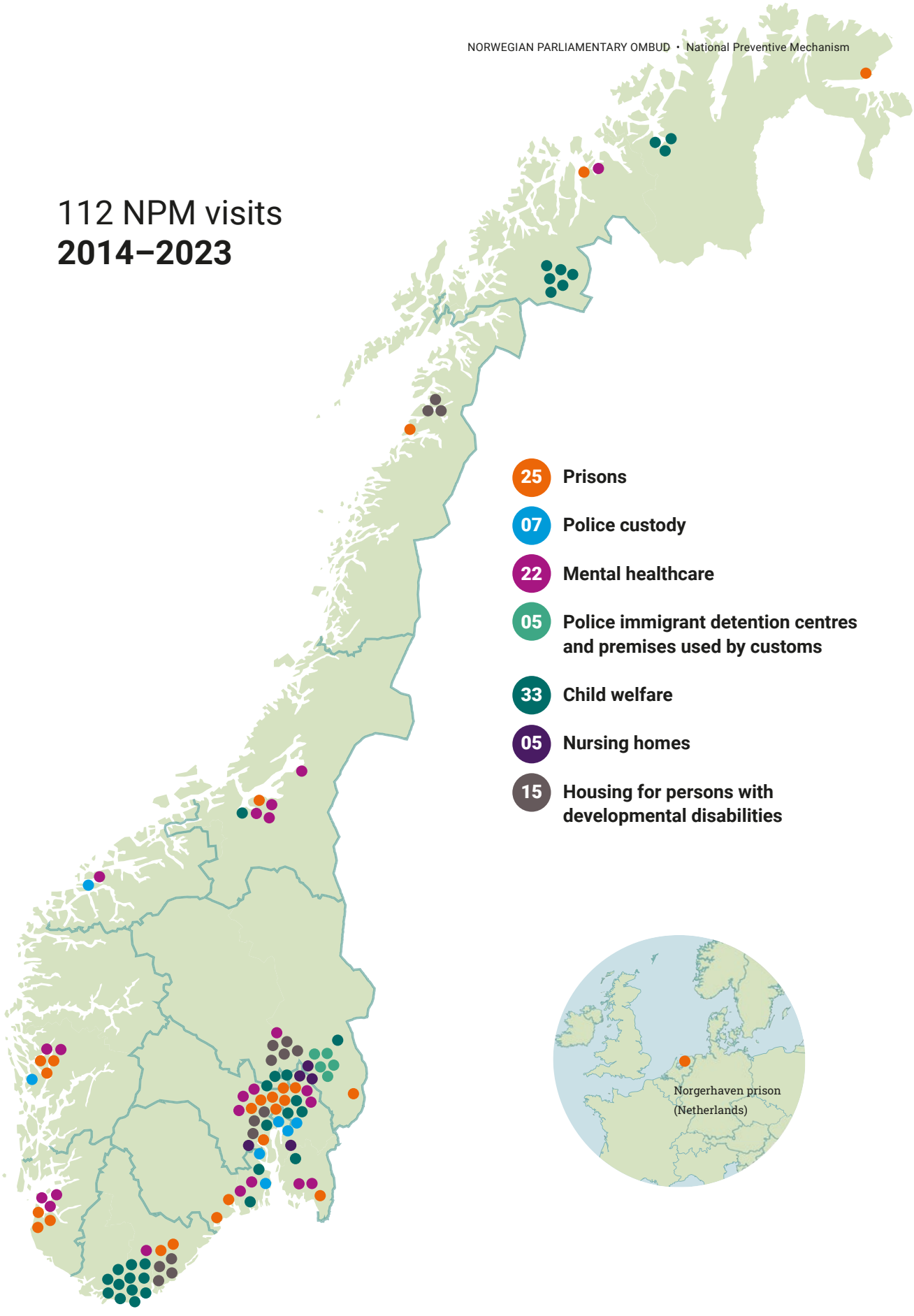
23
lectures and talks to national stakeholders

37
participation in conferences, meetings and various events

5
lectures for students

13
meetings with international stakeholders

112 NPM visits
2014–2023



Sectors covered by the NPM's mandate

58

PRISONS AND TRANSITIONAL HOUSING

127

DETENTION PREMISES USED BY THE CUSTOMS SERVICE

Approx. 115

POLICE CUSTODY FACILITIES, INCLUDING WAITING CELLS

3

POLICE IMMIGRATION DETENTION CENTRES

11

CUSTODY FACILITIES OF THE NORWEGIAN ARMED FORCES

1

INVOLUNTARY INSTITUTIONAL TREATMENT CENTRE (ØSTMARKA)

72

MENTAL HEALTHCARE INSTITUTIONS

Approx. 70

INSTITUTIONS FOR INVOLUNTARY TREATMENT OF PERSONS WITH SUBSTANCE

Approx. 20

RESTRICTIVE GOVERNMENT FUNDED PAROLE

Approx. 1000

CARE HOMES FOR ELDRELY

Approx. 150

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 2023

Category	Budget 2023	Accounts 2023
Salaries	10 122 500	9 890 945
Operating expenses		
Production and printing of visit reports, annual report and information material	250 000	119 070
Purchase of external services (including translation and interpreting services)	295 000	307 049
Travel (visits and meetings)	500 000	594 672
Other operating expenses	455 000	505 947
Share of the Parliamentary Ombudsman's joint expenses (incl. rent, electricity, IT services, security, cleaning etc.)	2 300 000	2 270 878
Total NOK	**13 922 500**	**13 688 561**

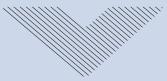
Photo: Scott Graham, Unsplash.

Photo: Parliamentary Ombud/NPM

How a NPM visit is carried out

Prepare for the visit and gather information

Conduct the visit

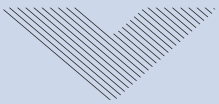


Write a report

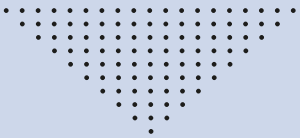
Publish the report with findings and recommendations

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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