SIVILOMBUDET
Norwegian Parliamentary Ombud

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Our ref.	Your ref.	Enquiries to	Date
2023/5496		Johannes F. Nilsen Aurora Geelmuyden	03.06.2024

Serious Concern About Prolonged Use of Restraint Belts in the Security Sections at Østfold Hospital

Background

In the autumn of 2023, the Parliamentary Ombud received concerning reports regarding the hospital's handling of a patient in one of the two local security sections at Østfold Hospital. The patient in question had been restrained to a bed continuously for almost 41 days (982 hours). We were also informed about another case where a patient had been restrained for about six weeks during an admission in the other security section.

The Parliamentary Ombud has previously expressed concern regarding the prolonged use of mechanical restraints after visiting the two security sections at Østfold Hospital in 2018. In the 2018 report, the Ombud criticized the prolonged use of belts over several days without documented assessments of whether the legal requirements for such restraints were met during the restraint periods. The Ombud was also concerned about a local culture which normalized the prolonged use of mechanical restraints. Prolonged belt restraints was a key point in our subsequent dialogue with the hospital about follow-up measures, which concluded in March 2021 after repeated rounds of written communication.

Considering the seriousness of the concerns we received in the autumn of 2023 and based on our previous concerns, the Parliamentary Ombud has chosen to follow up the case with Østfold Hospital.

The current case is not established as a complaint case, but is based on the Parliamentary Ombud Act § 17, second paragraph. This provision allows the Ombud to "conduct investigations" with a view to preventing torture and other cruel, inhuman, or degrading treatment or punishment. As a national preventive mechanism, the Parliamentary Ombud can make recommendations to improve the treatment and conditions for persons deprived of liberty and prevent torture and other cruel, inhuman, or degrading treatment or punishment. The responsible authority must review the recommendations and initiate a

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dialogue with the Ombud on possible implementation measures, cf. Parliamentary Ombud Act § 18.

When the state deprives individuals of their freedom, it has a positive duty to ensure that everyone involved in the treatment of the person performs their tasks and exercises their power in a way that fully protects the person from violation of the prohibition against torture and other cruel, inhuman or degrading treatment or punishment, as established in the UN Convention Against Torture and in Article 3 of the European Convention on Human Rights. This applies regardless of the reason and basis for the deprivation of liberty.

Data Collection and Dialogue with the Hospital
The Parliamentary Ombud contacted the hospital in a letter dated December 4, 2023, and requested the following:

- Patient records and other documentation related to the treatment of the specific patient.
- The hospital's explanation of measures taken to end the restraint.
- The hospital's procedures for the use of restraints.
- An overview of the ten longest restraint decisions in 2023.
- An overview of the ten patients with the highest number of restraint decisions in 2023.

In our letter of January 31, 2024, we requested additional information missing in the hospital's response letter of December 22, 2023, including the patient's restraint protocol. In a letter dated February 9, 2024, the Ombud requested further documentation related to the patient's case, including conducted violence risk assessments and discharge summaries from previous stays.

Furthermore, the Ombud has collected information about the ten longest restraint decisions and the ten patients with the most restraint decisions in 2023 at other local security units in Norway.

In April 2024, the Ombud sent a new letter to Østfold Hospital and a separate letter to the local supervisory commission. The letters included detailed explanations of the Parliamentary Ombud's concerns in the case and provided several examples from the patient's medical records to substantiate the Ombud's concern. Based on these, the Ombuds asked the hospital questions about both the prolonged restraint of the patient and the general practice of using restraints in the security sections. Based on the supervisory commission's handling of complaints in the case and its responsibility to monitor the use of restrictive measures, questions were also directed to the commission. Both the hospital and the supervisory commission have answered our questions. However, none of the responses reassured the Parliamentary Ombud about the situation for the specific patient, the use of mechanical restraints in the security sections, or the supervisory commission's control over the legal rights and conditions for patients restrained for extended periods.

The hospital has, in its response, largely focused on the background for the patient's compulsory mental health care and the legal basis for the patient's stay. Although these aspects can provide important information to the caregivers and the institution, such as the patient's behavioral patterns and what may constitute risk behavior, they cannot, in themselves, justify the use of restraints. Restraints can only be used as a last resort when it is the only way to prevent immediate or imminent harm to the patient or others in the specific situation.

The Legal Basis for the Use of Mechanical Restraints

The Constitution and Human Rights

Section 4-8 of the Mental Health Care Act authorizes the use of restraints in institutions for inpatient mental health care. Like other legislation, the Mental Health Care Act must be interpreted and practiced in accordance with human rights, cf. the Constitution § 92.

The Constitution § 92 states that "the authorities of the state shall respect and ensure human rights as set forth in this constitution and in treaties binding on Norway." By state authorities, this refers to all public bodies and institutions representing the authorities.[1] The obligation under the Constitution § 92 therefore presupposes that the administration assesses the relationship to human rights.[2]

The Constitution § 93, second paragraph, states that "no one shall be subjected to torture or other inhuman or degrading treatment or punishment." The same prohibition follows from ECHR Article 3, which reads: "no one shall be subjected to torture or to inhuman or degrading treatment or punishment."

The Supreme Court has stated that practice from the European Court of Human Rights (ECtHR) will be decisive in interpreting the Constitution § 93.[3]

The ECtHR has handled several cases on the use of mechanical restraints both in mental health care and in prisons.[4] The legal state following the ECtHR's previous decisions in the field is largely summarized in Aggerholm v. Denmark (ECtHR-2018-45439).

[1] Dokument 16 (2011–2012) Rapport til Stortingets presidentskap fra Menneskerettighetsutvalget om menneskerettigheter i Grunnloven punkt 9.4 side 47.
[2] Se statement by the Parliamentary Ombud 2. July 2020 (SOM-2020-292) om retten til kontradiksjon og håndtering av menneskerettslige anførsler i en sak om helse- og omsorgstjenester.
[3] HR-2021-1155-A, avsnitt 40
[4] Aggerholm mot Danmark dom 15. september 2020 (EMD-2018-45439), Herczegfalvy mot Østerrike dom 24. september 1992 (EMD-1983-10533), Bures mot Tsjekkia dom 18. oktober 2012 (EMD-2008-37679), M.S. mot Kroatia nr. 2 dom 19. februar 2015 (EMD-2012-75450), Henaf mot Frankrike dom 27. november 2003 (EMD2001-65436), Julin mot Estland dom 29. mai 2012 (EMD-2008-16563) og Wiktorko mot Polen dom 31. mars 2009 (EMD-2002-14612).

In this case, the ECtHR emphasizes that mentally ill individuals are particularly vulnerable, which affects the assessment of whether a treatment is compatible with ECHR Article 3.[5] The subordinate position and helplessness experienced by individuals detained in psychiatric hospitals are also significant.[6]

Regarding the use of mechanical restraints, the ECtHR states that such restraints can only be used as a last resort and when they are "the only means available to prevent immediate or imminent harm to the patient or others." Furthermore, the ECtHR points out that there must be sufficient justification to ensure that the requirements of absolute necessity and proportionality are met and that no other reasonable alternatives were suitable to limit the risk of harm to the patient or others. It must also be shown that the restraint used was not extended beyond the period strictly necessary for the purpose. The court also emphasizes that the patient must be under close supervision and that all use of restraint must be properly documented.[7]

In the abovementioned case, the ECtHR concluded that there had been a violation of ECHR Article 3 because the state had not sufficiently documented that the duration of the restraint, nearly 23 hours, was strictly necessary. The ECtHR emphasized that the restraint was decided to be maintained by the doctor even though the complainant, after a period of 5-6 hours, appeared "more quiet and talkative" and the doctor had "decided to release one ankle strap and allow the applicant to be released in connection with toilet visits and personal hygiene." The doctor's reason for maintaining the restraint four hours later was that the patient was still "potentially dangerous to other people because of his instinctive anger."[8] The ECtHR reminded in this context that "potential" danger is not sufficient - the danger of harm must be immediate or imminent.[9] The ECtHR also emphasized that for almost twelve hours, no assessment was made by a doctor as to whether the patient still posed a danger.[10] It also took one hour and 35 minutes from the doctor found it safe to release the patient from the restraints until it actually happened.[11] Referring to these points, the ECtHR concluded with a violation of ECHR Article 3.[12]

The Mental Health Care Act and Mental Health Care Regulations

Section 4-8 of the Mental Health Care Act authorizes the use of restraints (including mechanical) in institutions for inpatient mental health care. The purpose of the provision is to authorize measures that can be used in emergency-like situations where the patient has aggressive and uncontrolled behavior that can harm the patient themselves or others or cause significant material damage.[13] The first paragraph reads:

[5] Aggerholm mot Danmark dom 15. september 2020 (EMD-2018-45439), avsnitt 79 og 81.
[6] Avsnitt 83.
[7] Avsnitt 84 og 85.
[8] Avsnitt 111.
[9] Avsnitt 111.
[10] Avsnitt 112.
[11] Avsnitt 113.
[12] Avsnitt 114.
[13] Ot.prp.nr.11 (1998-1999) merknadene til § 4-8.

"Coercive means shall only be used in respect of the patient when this is absolutely necessary to prevent him or her from injuring himself or herself or others, or to avert significant damage to buildings, clothing, furniture or other things. Coercive means shall only be used when milder means have proved to be obviously futile or inadequate."

Restraints can only be used if less intrusive measures (milder means) do not work or are clearly insufficient. The Directorate of Health mentions in its circular that milder means can, for example, be verbal approach, change of staff, or inserting more staff, use of segregation or possibly other restraints that the patient considers less intrusive.[14] The requirements that it must be absolutely necessary to use restraint and that milder means must be tried are set to emphasize that "such measures are reserved for extreme and otherwise unmanageable situations."[15]

The implementation of restraints must not be delayed until someone or something is actually harmed, but there must be a situation that involves a real danger of significant or considerable damage based on an objective assessment.[16] The preparatory works of the Act states that even if the patient verbally threatens the staff, it is not certain that this constitutes real danger. It further states that the assessment cannot be based on a "precautionary principle".[17] Restraints cannot generally be used preventively, for example, against a person who is not currently aggressive or a patient who is sleeping.[18]

Section 4-8 of the Mental Health Care Act does not explicitly state how long a mechanical restraint can be used. Neither does the preparatory work mention the duration. The wording of the law "restraints shall only be used…" suggests that the requirement that the use of restraint must be absolutely necessary applies as long as the intervention is ongoing. The purpose of the provision, that it should be an emergency-like authorization for harm prevention, also supports the requirement of absolute necessity must be met as long as the restraint is maintained. This is also in line with section 4-2, first paragraph, of the Mental Health Care Act, which states that restraint shall be limited to the strictly necessary, and section 26 of the Mental Health Care Regulations, that the use of restraints must always be as short as possible.

The patient shall have continuous supervision by care staff. When restrained to a bed or chair, care staff shall remain in the same room as the patient unless the patient opposes this and it is professionally justifiable to leave the patient alone.[19]

[14] IS-2017-1 punkt 1.4.10, kommentarer til § 4-8.
[15] Ot.prp.nr.11 (1998-1999) punkt 8.8.4.4.
[16] Ot.prp.nr.11 (1998-1999) punkt 8.8.4.3.
[17] Ot.prp.nr.11 (1998-1999) punkt 8.8.4.3.
[18] Helsedirektoratets rundskriv IS 2017-1 Psykisk helsevernloven og psykisk helsevernforskriften med kommentarer, punkt 1.4.10.
[19] Psykisk helsevernloven § 4-8 fjerde ledd og psykisk helsevernforskriften § 26 andre ledd.

The use of restraint measures must always be carried out in a responsible manner, and restraint use should be prevented as far as possible with sufficient staff and professional competence, cf. Specialist Health Service Act § 2-2 and Mental Health Care Regulations § 4, last paragraph.

Norwegian legislation, including the requirement that belt restraint must be "absolutely necessary" throughout the entire process, seems largely in line with the criteria set by the ECtHR as outlined in Aggerholm v. Denmark. In any case, Norwegian legal provisions must be interpreted in accordance with the ECHR, and in the event of a conflict, the ECHR shall prevail, cf. Human Rights Act § 3, cf. § 2.

Decisions on mechanical restraints shall be made by the responsible professional, usually a specialized doctor or psychologist.[20] This requirement is set to ensure that the decision-maker must have particularly good competence to assess the need for the use of restraint and the impact restraint use may have on the patient's mental and possibly somatic condition.[21] If an acute emergency makes immediate contact with the responsible professional is impossible, the department's responsible person can still make the decision.[22] In such cases, the professional who is responsible must be informed as soon as possible. For continued use of restraints, the responsible professional must decide whether the use of restraint should be maintained.[23]

Decisions on mechanical restraints must be recorded without delay.[24] Before a decision is made on the use of a mechanical restraint, the patient should be given the opportunity to express themselves, if possible, cf. Mental Health Care Act § 4-2, second paragraph.[25] The provision also states that the patient's statement about previous experience with restraint measures should be particularly emphasized, and the information should be recorded.

Serious Concern About Very Long Belt Restraint

Due to confidentiality considerations, the Ombud only provides limited information about the specific case here. Through the Ombud's letter of April 18, 2024, the hospital will be familiar with the more detailed basis for the Ombud's strong concern in the case.

The patient in question was restrained for almost 41 days (982 hours) in 2023. The patient was also restrained for over 24 hours, a few months before the very long belt restraint. Both restraint decisions were justified by fear that the patient would harm themselves or others.

Some time before the first restraint incident, the patient was admitted to a regional secure psychiatric unit at another hospital for several months. During this period, no decisions were

[20] Psykisk helsevernloven § 4-8 femte ledd. For hvem som kan kvalifisere for å være faglig ansvarlig, se psykisk helsevernloven § 1-4 og psykisk helsevernforskriften § 5.
[21] Ot.prp.nr.65 (2005-2006) punkt 10.5.4
[22] Psykisk helsevernforskriften § 25 andre ledd.
[23] Psykisk helsevernforskriften § 25 andre ledd.
[24] Psykisk helsevernloven § 4-8 femte ledd andre setning
[25] Psykisk helsevernloven § 4-2 tredje ledd, jf. tredje ledd nummer 5.

made to use restraints or impose restrictions on the patient. When transferring the patient back to Østfold Hospital, the regional secure psychiatric unit conveyed several recommendations, including how the use of restraint could be prevented. Our review of the documents shows that Østfold Hospital appears to have followed these recommendations to a limited extent.

During the period between the two restraints, the patient was also subjected to extensive restrictions. They were subjected to a segregation decision under section 4-3 of the Mental Health Care Act and were therefore separated from the other patients. For much of the period, the patient was also deprived of their mobile phone following a decision to restrict contact with the outside world under section 4-5, second paragraph, of the Mental Health Care Act. The document review revealed that the hospital practiced strict enforcement of house rules, which seemed to have contributed to increased conflict levels between the staff and the patient. At the same time, we could not see that the segregation plans included any form of activities.

During this period, it is noted in the ongoing patient records that the patient expresses frustration over how little is happening in the department, that they do not feel heard by the staff, and that they are "about to lose it soon." It is also noted in the records that the patient is frustrated about not being able to listen to music or watch series and wants more stimulation.

Furthermore, we have seen entries in the patient records indicating that staff have contributed to escalating situations that ended with the use of restraint against the patient. In one case, an employee writes in the patient file that they tell the patient during a heated discussion that if the patient wants to fight, they can start hitting. The employee also communicates that the alarm will not be used if the patient wants to fight. We cannot see traces of the management following up on the employee's conduct after the incident, and in their response to us, the hospital communicated that they do not consider such behavior problematic.

The notes from the responsible professional treatment provider on the day the long-term belt restraint started leads to significant concerns about the staff's ability to communicate to de-escalate conflicts and prevent restraint. The relevant patient record entry is reproduced in its entirety in previous communications with the hospital as the Ombud considers this problematic in light of the conditions for using restraints.

Only four days after the decision that led to nearly 41 days in the restraint bed was implemented, we find a documented assessment from the responsible professional treatment provider of whether the patient should still be restrained. The detailed entries from the nurse records in the four days following the restraint do not contain any assessments of whether the conditions for maintaining the decision are present. Also, further in the extraordinarily long belt restraint period, there are significant gaps in the documentation of continuous assessments of whether the decision should be maintained, i.e., whether the conditions are still met during the restraint.

Several of the entries from the restraint supervision are characterized by standard texts and leave doubt as to whether the assessments are the result of concrete evaluations of the patient. Neither in the treatment nor nursing parts of the patient's records can we see that continuous assessments of whether it is absolutely necessary to maintain the decision on mechanical restraints are documented. The only places in the records where we find explicit assessments of whether the conditions for the decision on mechanical restraints are met are in weekly conversations between the responsible professional treatment provider and the patient. On the contrary, there are numerous indications in the patient's journal suggesting that the conditions for using restraints were not met throughout the period. The patient is described in several places as calm and sleeping.

In a journal entry from an on-call doctor, the following is noted: "Conversation: The patient appears awake lying in bed calmly [...] Assessments/measures: The patient is awake. Due to continued significant unrest, threatening communication and behavior with psychotic traits, the belts are not released now. Restraint is continuously assessed."

Another example similarly reproduces conflicting information, raising doubt about whether the assessments made are genuine: "Assessment/measures: The patient is sleeping. Due to continued significant unrest, threatening communication and behavior with psychotic traits, the belts are not released now. Restraint is continuously assessed."

The lack of continuous assessments of the conditions characterizes the entire extraordinarily long belt restraint period. The Ombud considers the absence of documented continuous assessments as a very serious breach of legal safeguards, posing a high risk that the patient has been restrained without the conditions being met.

The document review further reveals that the restraint causes the patient great pain and humiliation. There are no traces in the documents that these conditions are assessed in light of the requirement that the use of restraint must be proportional. Shortly after being restrained in the bed, the patient experiences problems with urination and defecation, and the challenges persist through much of the period they are restrained. This contributes to painful and very degrading situations for the patient. In several journal entries, the patient is described as being in pain, among other things, lying on a weeping sore. They are catheterized, causing pain, and it is primarily arranged for defecation to take place while lying in belts with a bedpan. It is recorded in the records that the patient themselves experiences urination and defecation in bed as so degrading that they wait as long as possible.

While the patient was restrained, they asked to call their lawyer. This was denied twice, citing that the patient has an hour of phone time in the morning. In one instance, it was just after 10:00 AM when the patient asked to speak with the lawyer, and they were told to wait until the phone time from 9:00 to 10:00 AM the next day. In another instance, an afternoon 10 days later, the patient again asked to speak with the lawyer and was given the same response that this must happen between 9:00 and 10:00 AM. We cannot see that the

hospital has the authority to restrict the ability to contact a lawyer when subject to the use of restraints.

Supervisory Commission

The supervisory commission's task is to safeguard the legal rights of persons treated in mental health care through the control of coercive decisions, complaint handling, and welfare control in the form of on-site supervision. The supervisory commission plays a central role in safeguarding the legal rights of patients, and it is therefore important that the commission is thorough in its investigations and maintains a fundamental independence from the hospital. The Ombud reminds the Supervisory Commission of our national investigation of the commissions' handling of complaints about the use of belts (mechanical restraints) in mental health care in 2022.[26]

The supervisory commissions must in all cases provide an independent and concrete justification that the condition of absolute necessity in the Mental Health Care Act § 4-8 was met for the entire period mechanical restraints were used. The longer a restraint measure lasts, the more intrusive it will be for the patient.

The Supervisory Commission reviewed the long-term belt restraint on two occasions. The Commission's first review took place several weeks after the restraint was implemented and only after a complaint from the patient. We cannot see that the Commission before this had investigated the very long belt restraint as part of its control of the hospital's use of restrictive measures.

In the hospital's decision, there was no description of any assessment of whether the situation could have been resolved with milder means when the decision was implemented, cf. Mental Health Care Act § 4-8, first paragraph, second sentence. The Ombud cannot see that the Supervisory Commission addressed this and conducted an independent assessment of whether the hospital could have used milder means.

In the decisions, the Commission has largely referred to the hospital's explanations without writing its own justifications for its conclusion.

In the first decision, the Commission referred to "attaching importance to" a note from the professional responsible, which was recorded three days before the time of the complaint handling. We cannot see that it is documented that the Commission has considered other assessments of the patient's condition that were closer to the decision time in time or an independent assessment of information regarding the development of the patient's condition in the ongoing and until then 21-day long belt restraint period. The Ombud cannot otherwise see that the consideration of public safety and the possibility of being outside the

[26] Sivilombudet (2022) Kontroll med bruk av mekaniske tvangsmidler i psykisk helsevern. En undersøkelse av kontrollkommisjonenes praksis, saksnr. 2022/1184.

hospital, which was emphasized in the journal note, is legally relevant when assessing whether it is "absolutely necessary" to maintain a decision on mechanical restraints.

The decision contains no information about the development of the patient's condition beyond the belt restraint period and no justification that is suitable to show that the restraint measure was absolutely necessary for the entire period. It was not clear from the Commission's decision whether the condition was assessed for the entire period from the implementation to the decision time. There is also nothing in the decision about the burden the belt restraint imposed on the patient, despite the fact that the belt restraint had then lasted for three weeks, and the patient had extensive complaints during the belt restraint as described above.

Similar deficiencies also characterize the second decision from the Supervisory Commission, made at a time when the belt restraint had lasted for about 31 days. The Commission's justification also seems in this decision largely based on a direct reproduction of excerpts from two patient notes from the weekly conversations of the professionally responsible with the patient while they are in fixated to the bed. The Commission concludes that "the hospital's decision is professionally justified in a good manner." However, it is difficult for the Ombud to see which specific aspects and assessments the Commission is basing its conclusions on here.

The Commission's response to our questions gave the Ombud few indications that thorough and concrete assessments of the patient's situation have been made and whether the conditions were actually met throughout the restraint period. Instead, the Commission expresses that the decision on restraint was "obvious" and that the Commission wanted to support the professionally responsible, who felt that the patient did not respect them as the treatment provider. It is our understanding that the reason for the lack of a more thorough justification in the decision was that the Commission wanted to protect the patient from reading the details of the justification for the restraint measure they were subjected to. These explanations suggest that the Commission does not fully understand its role in safeguarding the individual's legal rights in their interaction with the mental health care system. The Ombud takes this very seriously.

Serious Concerns regarding Local Leadership and Culture

Reviewing the belt restraint described above and the Parliamentary Ombud's previous concern about prolonged belt restraints at the two local security sections at Østfold Hospital makes the Parliamentary Ombud very concerned that prolonged belt use is still normalized and accepted at the hospital.

In connection with the investigation of this case, we obtained an overview of the length of the longest belt restraints in all local security units in the country in 2023.[27] The median duration of the longest belt restraints at 13 local security units is 8 hours and 15 minutes.

The two security sections at Østfold Hospital had issued eight decisions on the use of belts as of mid-December 2023. One belt restraint lasted 10 minutes, while the other seven decisions lasted over a day. Four of the decisions involving four different patients were very long. These lasted for approximately 12 days (302 hours), 40 days (957 hours), and 41 days (982 hours), while the fourth had lasted for 22 days (528 hours) and was still ongoing when the data was communicated to the Ombud. Other local security units did not have comparable lengths of belt restraints, except for one other security unit where one patient had several very long belt restraints. Østfold Hospital thus stands out nationally.

The hospital maintains in its response (letter of May 16, 2024) that the very prolonged use of extensive and severe intrusive restraint against the patient could not be avoided. However, the explanation from the hospital contains few new details about the circumstances or assessments that justify the need to keep the patient restrained to a bed continuously for nearly 41 days. The hospital's response, by failing to comment on several serious issues highlighted in the Ombud's letter, also contributes to our concern. The hospital's response seems to defend the decisions made and suggests that the management neither understands the severity of the revealed failure nor the suffering inflicted on the patient as a result of the extraordinarily long restraint measure according to the hospital's own documentation.

In the letter to the hospital, the Ombud asked which health personnel are responsible for ensuring that continuous assessments are made of whether the conditions for using restraints are met and how often such assessments should be made at a minimum. The hospital responded that it is the professionally responsible who should assess the need for continued use of restraints based on a comprehensive risk assessment from observations by health personnel who are continuously with the patient. It is our understanding that the hospital here refers to the professional responsible treatment provider, who during the prolonged belt restraint period only conducted weekly assessments of whether the use of belts should continue. The requirement for continuous assessment of whether the conditions for using belts are met, assumes that the hospital is organized in a way which ensures that there at all times is a staff member available with the sufficient authorization to release the belts. There was nothing in the hospital's response that suggested that it was organized in such a way. The hospital's feedback has thus reinforced our concern about the extent of the use of force and the use of mechanical restraints in the security sections.

Conclusion

The Parliamentary Ombud's assessment is that the hospital's handling of the belt restraint process described above entails a high risk that the prohibition against inhuman and

[27] We have received responses from 14 out of 16 security units; 13 of these responses are provided in a way that they can be used to calculate the median

degrading treatment in ECHR Article 3 has been violated in the specific case. According to the ECtHR's case law and the UN Convention Against Torture, the authorities must, on their initiative, conduct prompt and impartial investigations in cases where there are sufficiently clear indications that inhuman or degrading treatment has occurred and this is known to the authorities.[28] The seriousness of the case suggests, in our opinion, that state authorities must initiate their investigations in this case.

Considering the length of prolonged belt restraints compared to other security units, findings from our previous visit, and the hospital's responses, the Ombud is concerned that patients at the hospital risk being restrained for prolonged periods without measures providing protection against torture or other inhuman or degrading treatment. We are concerned about a local culture where prolonged belt restraint is accepted and normalized. It is a leadership responsibility to address such challenges. The Supervisory Commission's very inadequate handling of the patient's complaints and the Commission's responses to our questions also make us concerned about the protection of the legal rights of restrained patients by the responsible oversight body and whether there is a real and objective review of the hospital's practices.

The Parliamentary Ombud considers the findings at the security section very serious and requests the hospital to provide a written explanation of what they will do to ensure that the hospital does not violate the fundamental rights of admitted patients through the use of mechanical restraints. The explanation shall be sent to the Parliamentary Ombud by June 26, 2024.

Before this deadline, we wish to meet with the hospital's chairman and director. We propose Friday, June 21, 2024, at 1:00 PM. We ask that confirmation of the meeting time be sent to Senior Advisor Aurora Geelmuyden by email: age@sivilombudet.no.

Hanne Harlem
Parliamentary Ombud

Helga Fastrup Ervik
Head of the NPM Unit

This letter has been electronically approved and has no handwritten signature.

[28] EMD, dom 3. mai 2007, Members of the Gldani Congregation of Jehovah's Witnesses and others mot Georgia, klagenr. 71156/01, avsnitt 97. Se også FNs konvensjon mot tortur og umenneskelig behandling, artikkel 12 jf. Artikkel 16.

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