SIVILOMBUDET
Norwegian Parliamentary Ombud

VISIT REPORT | no. 78

SUMMARY AND RECOMMENDATIONS

Agder prison, Froland Department

October 31.– November 2. 2023

National Preventive Mechanism against
Torture and Ill-Treatment

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Table of content

I. The Parliamentary Ombud's prevention mandate

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

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

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

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

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

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

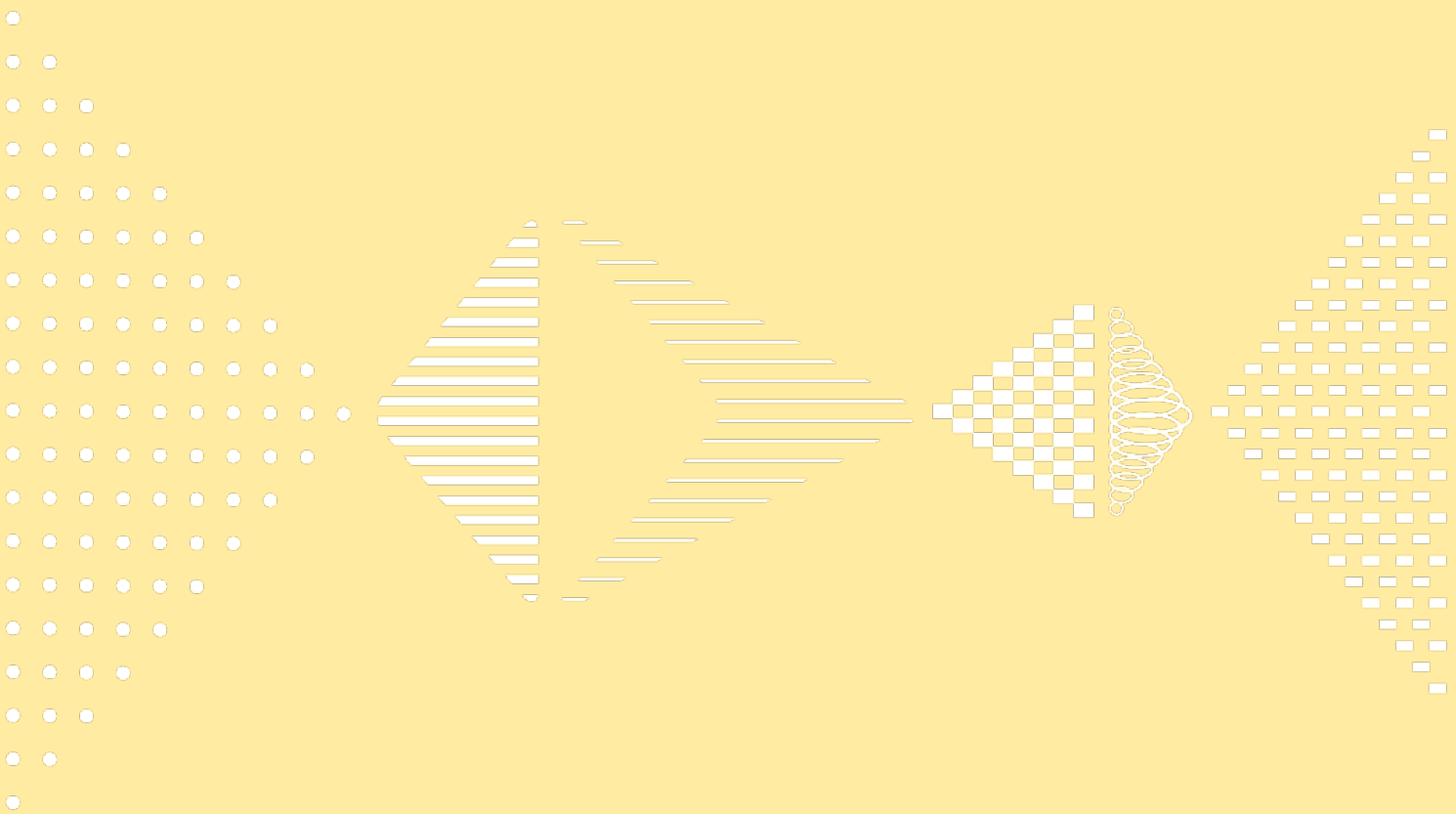
The Parliamentary Ombud’s assessments of conditions that pose a risk of torture and inhuman treatment are based on a broad range of sources. During the visits, the national preventive mechanism examines the conditions at the location through observations, interviews, and documentation reviews. Private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

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

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

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

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



II. Summary

The National Preventive Mechanism of the Parliamentary Ombud conducted a visit to Agder Prison, Froland Department, from October 31 to November 2, 2023. Froland Prison is a high security facility, which opened in 2020. The prison accommodates 200 male inmates. At the time of the visit, the prison had been operational for just over three years. Both inmates and staff, including management, felt the impact of a challenging budget situation and the effects of restructuring and cutbacks that led to a reduction in services, reduced staff presence, and increased lock-in times.

Lack of daily activities

Although the prison has a capacity for 200 inmates, there were only 129 full-time placements available for the prison's school or work programs. Thus, the prison lacked the capacity to provide daytime activities for all interested inmates. The way the prison was built limited did not give sufficient space dedicated to schooling and work, exacerbating the shortage of places.

Limited use of interpreters

It was noted that the prison very rarely used interpreters. The health department also did not use interpretation services in all necessary instances. For example, interpreters were not used in intake interviews with inmates who did not speak Norwegian or English, creating a risk that critical issues might not be uncovered during a particularly critical phase.

This led to feelings of insecurity, uncertainty, and loneliness among some inmates.

Language also posed a challenge in using the prison's digital self-service system, which inmates used to contact healthcare services, social workers, and for various applications/requests. While the self-service homepage appeared to offer information in many languages, the information within the system was only available in Norwegian and English. This restricted non-Norwegian or English-speaking inmates' access to information and services compared to other inmates.

Opportunities for contact with the outside world should be strengthened

As a rule, inmates had 1 hour and 32 minutes per week to contact family and other close relations.

Our assessment is that the prison limitations on inmates' contact with the outside world were too strict. It seemed only possible to apply for extra telephone time if you had children. This limitation does not comply with laws, regulations, or the prison's own procedures for extended telephone time. Additionally, we found that inmates had to choose between physical visits and video calls, a practice the National Preventive Mechanism finds problematic. Video calls are a vital supplement for maintaining contact with friends and family and have been repeatedly requested by the National Preventive Mechanism.

Isolation and lock-in

From the end of August 2023, the prison had to increase the lock-in times for inmates due to resource and staffing issues. This primarily affected inmates without daytime activities, who were locked in their cells while others were at work or school. This meant that many inmates did not have 8 hours outside their cells daily, which is the minimum standard set by the European Committee for the Prevention of Torture. This condition increased the risk of isolation of inmates without a formal prison or judicial decision to justify such measures. Increased lock-in also heightened the risk of conflict and insecurity among inmates and between inmates and staff, undermining the staff's ability to effectively maintain relationships, security, and rehabilitation efforts.

Use of coercion

A review of decisions to place inmates in high-security cells indicated that the prison should improve the quality of their explanations for why less intrusive measures were not attempted and whether the use of force was proportional. It should be clearly stated in all decisions why exclusion or placement in a high-security cell is necessary.

Need to strengthen efforts to prevent suicide

According to the Correctional Service's procedures, all inmates should be assessed for suicide risk by the prison at intake. If an inmate indicated issues related to mental health, suicidal thoughts, or self-harm, an individual care plan should be developed in collaboration with the health service. Although such care plans were established in several cases, both at intake and when later risks were identified, the measures were generally limited to regular monitoring and, in some cases, placement in a cell with a breathing sensor. This is insufficient. We found no examples of using family support, increased telephone time, or similar supportive measures. There was little evidence of collaboration with the health department in these plans.

Healthcare services for inmates

Froland Municipality was responsible for healthcare services in the prison, while Sørlandet Hospital managed outpatient specialist health services.

Our review of documentation from the municipality generally showed good quality in healthcare content, but there were clear shortcomings in health assessments, medication management, continuity of care, use of interpreters, and follow-up of isolated inmates. There was also some variability in the healthcare provided within the prison. Many inmates and staff felt that healthcare was dependent on the individual provider.

When it came to health assessments, it was unclear if the health department conducted these within 24 hours after intake. We also found no documentation that the municipality ensured that health assessments were conducted outside of health department hours, and many intake notes lacked assessments of self-harm and suicide risk. The National Preventive Mechanism has repeatedly stated that health assessments at intake should not be delayed in such cases.

A review of health assessments also showed that measurements of vital parameters often were unsystematic or missing, and there was a lack of assessment for withdrawal symptoms. We also noted that there was little consideration of follow-up based on the young age of inmates aged 18-24 and their possible need for additional support.

Risk of improper medication handling

Proper medication handling requires a system to ensure that the correct medication is given to the right patient, in the correct dose, at the right time, and in the right way. Reported medication discrepancies, unlocked medication carts, and uncertainties about officers' access to confidential health information posed a clear risk of improper medication handling in the prison.

Lack of documentation of healthcare follow-up of isolated inmates

Inmates who are isolated are in a particularly vulnerable situation that requires thorough and independent follow-up by the healthcare service. We found that in many cases, there was no documentation on how the health department followed up on isolated inmates. Both the lack of supervision and the lack of journaling of supervision can result in inmates' health conditions under

isolation not being assessed and a negative health development not being promptly addressed. This also makes it difficult to verify what happened or what actions were taken.

III. Recommendations

Daily activities

1. The prison should, as far as possible, ensure that all inmates have a daytime offer in the form of work, education, or training.

Safety

2. The prison should secure the feeling of being safe for both inmates and staff through increased presence of prison officers.

Communication and use of interpreters

3. The prison should provide an interpreter during the intake interview for all inmates who do not have sufficient language skills. Interpreters should also be used when important information needs to be conveyed or inmates wish to communicate information to the prison. The offer and use of an interpreter should be documented.

4. The prison should ensure that all inmates, regardless of language, have equal access to information and services.

5. The prison and Froland municipality should ensure that inmates can approach the health department without person-sensitive and confidential information being accessible to unauthorized persons.

Contact with the outside world

6. The prison should enhance inmates' opportunities to contact the outside world, especially through phone calls, video calls, and visits with friends and family.

Isolation and lock-in

7. The prison should ensure that all inmates that is not legally isolated can spend at least eight hours outside their cells each day and engage in meaningful activities, including weekends.

8. The prison should develop clear guidelines for the use of enhanced cells in the S+ wing.

9. The prison should ensure that all decisions about exclusion clearly describe the consequences of the decision for the inmate.

Restraint bed

10. The restraint bed in the prison should be abolished. Until then, the safety bed should be positioned so that it is not visible to inmates who are in security cells or for other reasons passing through the premises.

Decisions on placement in security cells

11. The prison should ensure that all decisions on placement in security cells are made with legal authority and a concrete justification that meets all legal requirements.

Control measures

12. The prison should ensure that formal decisions are made when planned use of handcuffs is anticipated. The decision should include a justification and be subject to appeal.

Self-Harm, Suicide Attempts, and Suicides

13. The prison should ensure that inmates at elevated risk of suicide and self-harm are met with evidence-based preventive measures, such as increased human contact, care, and activation.

14. The prison should ensure that isolation is not used as a means to prevent or manage suicide risk.

Organization and cooperation in health care

15. The prison, the municipality, and the hospital should cooperate to implement health-promoting measures for inmates to prevent and reduce negative health consequences due to the staffing situation in the prison.

Health assessments

16. Froland municipality should ensure health needs are assessed and evaluated upon arrival and within 24 hours, also outside of health department hours. Suicide risk assessments should always be performed upon arrival.

17. Froland municipality should ensure assessment of substance abuse issues, including withdrawal states and vital parameter measurements.

18. Froland municipality should have a camera available so that any injuries to inmates can be documented in the journal.

19. Froland municipality should implement measures to ensure that young inmates receive age- and situation-appropriate information and follow-up.

20. Froland municipality should ensure that inmates at suicide risk are also followed up outside of health department hours, and that inmates in security cells are always seen by health personnel.

Medicine management

21. Froland municipality and Froland prison should together ensure a system for safe medication management to enhance patient safety and prevent the spread of health information.

Continuity in health care

22. Froland municipality, along with the prison, should ensure good information flow about new admissions, presentations, and transfers to prevent interruptions in inmates' health care.

23. Froland municipality and the prison should each keep track of canceled and postponed health service presentations, and together ensure that inmates receive necessary health care.

Health departments use of interpreters

24. Froland municipality should ensure the use of an interpreter in conversations with health personnel where inmates need it.

Health care for isolated inmates

25. Froland municipality should ensure daily supervision and follow-up of inmates who are isolated in their cells for large parts of the day, including inmates who are isolated by their own choice.

26. The municipality should ensure good record-keeping and oversight of conducted inspections, even when carried out by emergency medical services.

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

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