



SIVILOMBUDET
Norwegian Parliamentary Ombud

VISIT REPORT | no. 77

SUMMARY AND RECOMMENDATIONS

Halden Prison

17. – 19. October 2023



**National Preventive Mechanism against
Torture and Ill-Treatment**



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I. The Parliamentary Ombud's prevention mandate

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

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

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

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

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

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

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

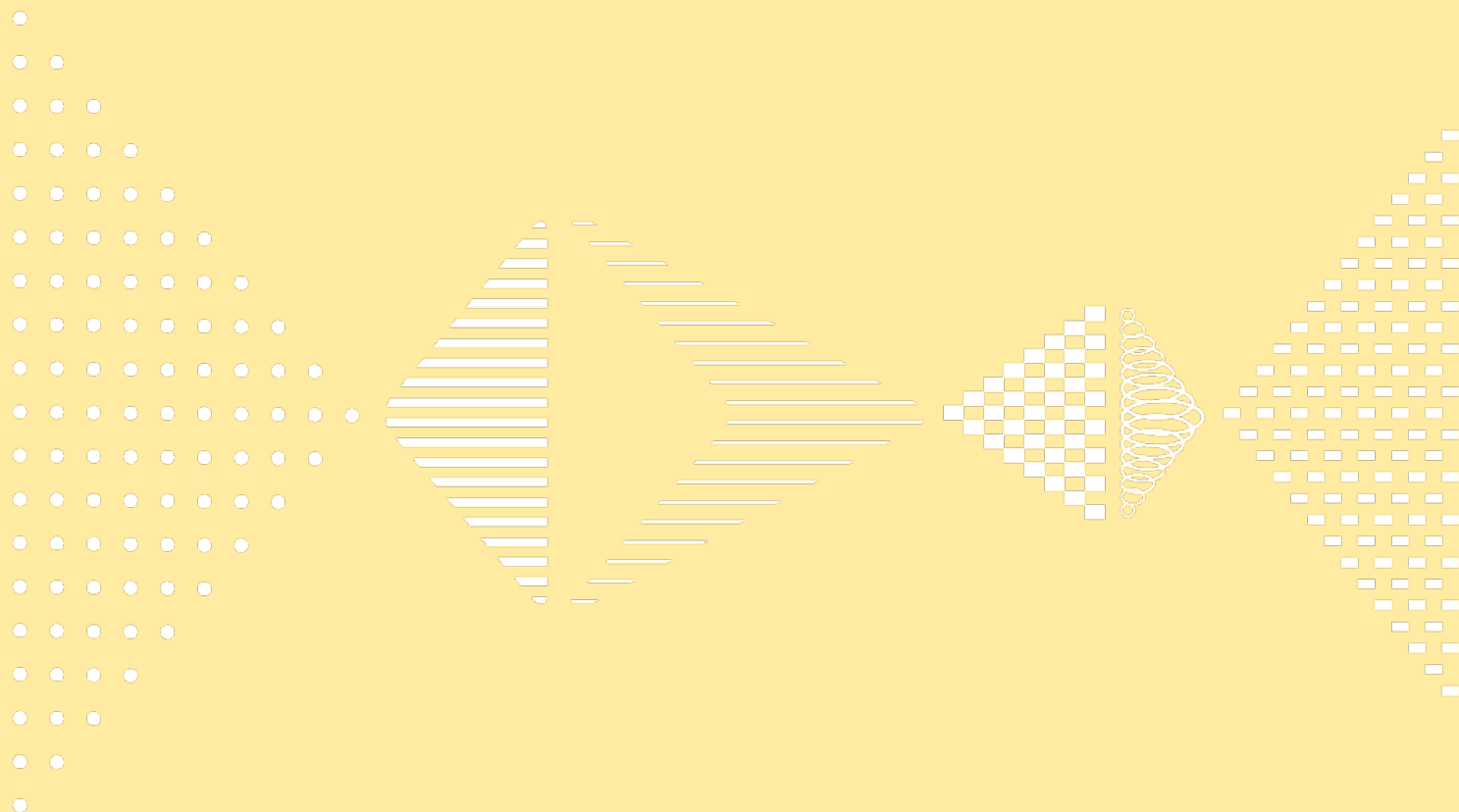
After each visit, a report is written, describing findings and recommendations for how the facility in question can prevent torture and other cruel, inhuman or degrading treatment or punishment.

¹ Sections 1, 17, 18 and 19 of the Norwegian Parliamentary Ombud Act.

² UN Subcommittee on Prevention of Torture (SPT), Prevention Mandate Recommendations, 30 December 2010 CAT/OP/12/6.

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

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



II. Summary

The Parliamentary Ombudsman's national preventive mechanism (NPM) conducted a visit to Halden Prison October 17th-19th, 2023. Halden Prison is a high-security facility which opened in 2010 and has 228 prison places for men.

Isolation, lockdown, and lack of daily activities

Inmates in several wards were not able to spend at least eight hours outside their cells daily, as recommended by the European Committee for the Prevention of Torture (CPT). In several wards, inmates were locked in their cells for more than 19 hours, and some for more than 22 hours in a day, even though no formal decision of exclusion had been made by either the prison or the courts. The prison also did not have an overview of the lockdown time for each inmate. In sum, this made it hard to know how many inmates were affected by extensive lockdown in their cells. The findings highlights the problems caused by the lack of a national minimum standard for time out of cell, which provides inmates with a satisfactory level of human contact and interaction.

No decisions were made when inmates were moved from the regular wards to the restrictive unit A1. The NPM considers it serious that inmates who were moved from the regular wards to the restrictive unit did not receive a decision regarding this change and that neither the reason for, purpose of, nor duration of the measures were documented.

The prison had four reinforced cells called "IUC" (in and out cells). The four longest stays in these cells from January to October 2023 lasted longer than a month; specifically 35, 39, 59, and 64 days. The design and location of the IUC, combined with the limited and unpredictable human contact and activity, caused significant risk of isolation for those who stayed there more than just short stays. As such, we found it particularly problematic that the documentation on how these inmates were followed up was insufficient and that some inmates were held in these cells for very long periods.

The possibility to engage in work and other daytime activities impacted inmates' ability to spend time out of cell. In recent years, there had been a reduction in the offered activities at the prison. It was unclear how many inmates were engaged in a daily program aimed at reintegration into society (targeted activities such as work, studies or training programmes), or who only had an activity aimed at reducing the risk of isolation (such as card games, various low-threshold activities, physical activity and conversations). It was no longer possible to study at university or college level at the prison.

Problematic staff reduction

The prison had undergone a significant reduction in staff in recent years, and both inmates and prison staff reported negative consequences for both inmates and staff. The management also expressed concerns about the reduced staffing levels and felt that it led to increased static security, such as locked doors and technological surveillance, and less dynamic security through the physical presence of officers.

Concerns regarding the lacking use of interpreters

The prison had several inmates who did not, or hardly, understood Norwegian or English. Nevertheless, it appeared that the prison very rarely called for an interpreter. Our findings indicated that interpreters were not used during the intake interview, where mental health, medication use, and suicide risk are assessed. The lack of use of interpreters in the prison, especially during the intake phase, was concerning.

A need to increase inmates' possibility to contact friends and family

Contact with the outside world is important for both inmates and their families. It can alleviate the experience of isolation and help maintain relationships that are crucial for successful reintegration into society. Our review of the prisons' responses to applications for extended contact revealed a lack of understanding of the inmates' need for contact with friends and family. The review of responses to visit permit applications also showed that the prison did not make specific assessments of whether a person should be denied a visit or if control measures during visits were necessary. Overall, the prison seemed to apply too strict limitations on contact with family and friends.

Use of Coercive Measures

In certain decisions, it was difficult to understand why it was deemed "strictly necessary" to use a security cell, and where it was not documented that less intrusive measures had been considered. Findings indicated that inmates were not allowed to speak with a lawyer while they were in a security cell. No decisions were made regarding the use of handcuffs during transfers outside the prison. This aligns with the guidelines of the Execution of Sentences Act, but in the preparatory work for the introduction of a new coercive measures, the Ministry of Justice has concluded that the predetermined use of, for example, handcuffs, is an administrative decision that must include a justification and be open to appeal. The NPM agrees with this legal interpretation and will address the matter with the Directorate of the Norwegian Correctional Service.

Evaluations after deaths in prison.

In 2022 and 2023, there were three deaths in Halden prison. One was classified as suicide, and the other two as natural deaths. The internal evaluations included a clear account of the prison's crisis management, including an assessment of what worked well and what did not in the situation. However, none of the documents contained any assessment of what had been done before the deaths to prevent them. This is a significant weakness. There is a clear need to improve the quality of the prison's internal evaluations following a death, to ensure learning both in the individual prison and in the correctional service as a whole.

Inmates Sentenced to Indefinite Preventive Detention

During our visit, there were seven people serving indefinite preventive detention sentences (forvaringsstraff) in the prison. In its first and second biannual reports for 2023 to the Correctional Service, Eastern Region, Halden Prison clearly expressed that it lacks the resources required to follow up on inmates sentenced to preventive detention. This matched the findings of the NPM during our visit, namely that inmates serving indefinite preventive detention did not receive a specially adapted program, as the regulations stipulate. It is concerning that individuals sentenced to indefinite preventive detention do not receive the follow-up that is a prerequisite for such sentences.

Delayed and Inadequate Health Assessments upon Admission

International standards require a health assessment of inmates within 24 hours of arrival at the prison. Of the 20 cases we examined, only about half had a complete intake interview within the first day. Additionally, we found deficiencies in the assessment of suicide risk at admission and inadequate documentation of physical injuries an inmate had, upon arrival at the prison.

Risk of Unsafe Medication Management

Medication dispensers with inmates' names and information were found unlocked in the staff offices in the units. Findings indicated that the routine requiring inmates to sign when receiving habit-forming medications was not always followed. Failures in the storage and distribution of medications increased the risk that inmates did not receive their medications, received the wrong dose, or received medications they should not have had. Uncertainties about whether medications had been distributed or not were a source of conflict between staff and inmates.

Serious Failures in Health Follow-up of Isolated Inmates and Lack of Professional Independence

Health personnel are supposed to have a free and independent role in the correctional service. In a prison, health personnel have a particular and independent responsibility to care for patients in situations that may cause them health damage. Findings suggested that some health personnel have been involved in advising the correctional service on the use of coercion such as placements in reinforced or security cells. This violates their independence and role as healthcare providers. Furthermore, health personnel should visit isolated inmates upon placement in isolation and then daily. They should provide prompt medical assistance and treatment. Any harmful effects on the inmate's physical or mental health must be immediately reported to the management. Inmates isolated by court order did not receive regular health follow-ups at the time of the visit. The health department changed the routine immediately after the NPM's visit and now conducts daily visits to inmates isolated by court order. It was not arranged for all inmates who were isolated by the prison to have daily visits by health personnel. Our review indicated a serious failure in the health department's follow-up of isolated inmates.

Inmates with Particularly Extensive Health and Care Needs

Several inmates had significant and serious health problems, and observations during the visit, interviews, and documents provided strong grounds for concern regarding these inmates. We missed more systematic cooperation between the prison and the health department to follow up on inmates with extensive health and care needs and ensure them a proper and dignified stay in prison. Furthermore, there was a lack of clearer routines to ensure follow-up in cases where the health department and/or the prison deemed that an inmate was not fit to serve in prison.

III. Recommendations

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

Recommendation: Prison Life

1. The prison should, as far as possible, ensure that all inmates have daily activities in the form of work or education.
2. The prison should facilitate access to higher education for inmates.
3. The prison should maintain a record of deviations from planned activities for the inmates.
4. It should be ensured that all inmates have a contact officer and that the inmates understand the role and responsibilities of their contact officer.
5. All inmates, including those who are isolated, should be given the opportunity for at least one hour of outdoor time daily. Outdoor time should be scheduled during daylight hours, and outdoor areas should have roofs or other protection against precipitation.
6. The prison should improve the safety of both inmates and staff through increased presence of prison officers.
7. The prison should provide an interpreter during the intake interview for all inmates who do not have sufficient language skills. An interpreter should also be used when important information is to be communicated or when inmates wish to convey information to the prison. The offer and use of an interpreter should be documented.
8. The prison should not limit the inmates' right to self-determination beyond what is necessary and proportionate.

Recommendation: Contact with the Outside World

9. The prison should strengthen inmates' opportunities for contact with the outside world, especially contact with friends and family through phone calls, video calls, and visits.
10. The prison should ensure that a specific assessment is made of whether a glass wall is necessary as a control measure during visits and whether the visitor's previous criminal behavior should lead to a denial of visit permit.

Recommendation: Lockdown and Isolation

11. The prison should ensure that all inmates who are not legally isolated can spend at least eight hours outside their cell each day and engage in meaningful activities, including on weekends.
12. The prison should ensure that inmates who are excluded from work and/or recreational activities and transferred to restrictive units or placed in reinforced cells (IUC), receive a formal decision regarding their isolation.
13. The prison should intensify its efforts to minimize the risk of harm associated with isolation for all affected inmates.

Recommendation: Use of Coercive Measures

14. The prison should implement measures to ensure that all decisions regarding security cells are made legally, with a specific justification demonstrating that the legal conditions are met.

15. The prison should find a solution for distributing food and drink in security cells that ensures inmates are treated with respect and dignity.
16. The prison should implement measures to ensure that inmates who wish to contact a lawyer while in a security cell have the opportunity to do so.
17. The prison should strengthen its efforts to prevent isolation and the use of coercive measures. Inmates should be involved in this work.
18. The prison should ensure that decisions regarding body searches are justified in accordance with current requirements and that the justification is available to the inmates.
19. The prison should ensure that body searches are conducted by staff of the same gender as the person being searched.
20. The prison should ensure that formal decisions are made when planned use of handcuffs is required. The decision must include a justification and be subject to appeal.

Recommendation: Self-Harm, Suicide Attempts, Suicide, and Deaths

21. The prison should ensure that inmates at increased risk of suicide and self-harm are met with evidence-based prevention measures, such as increased human contact, care, and activation. Isolation should not be used to prevent self-harm and suicide.
22. The prison should ensure that isolation is not used as a means to prevent or manage suicide risk.
23. Inmates should be informed about the possibility of calling helplines, and such numbers should be pre-approved to ensure inmates have quick access to support when needed.
24. The prison should ensure that a review of possible learning points is conducted after any death in the prison.

Recommendation: Health Assessment

25. Halden Municipality should ensure the assessment of health needs upon intake and no later than within 24 hours.
26. Halden Municipality should ensure routine assessment and documentation of self-harm and suicide risk in the patient's medical record.
27. Halden Municipality should ensure that inmates with physical injuries that may indicate violence or use of force upon intake are examined, and that the extent of injuries and photos are documented in the patient's medical record. The health department should have its own camera available.

Recommendation: Appointments with Health Services (Appointment Slips)

28. Halden Municipality and the prison should jointly ensure that inmates can quickly and directly contact the health department without confidential health information becoming available to unauthorized persons.

Recommendation: Medication Management

29. Halden Municipality should, together with the prison, ensure a system for proper medication management to strengthen patient safety and prevent the spread of health information.

Recommendation: Continuity in Health Follow-Up

30. Halden Municipality should, together with the prison, ensure good information flow about new admissions, presentations, and transfers to prevent interruptions in inmates' health care.
31. Halden Municipality and the prison should each keep track of canceled and postponed health service presentations.
32. When inmates are decided to be transferred to another prison, the prison should ensure that the health service is involved as soon as possible to ensure the transfer of patient information with the patient's consent.
33. Halden Municipality should ensure that inmates with appointments in specialist health services receive information about the time of the appointment, unless security reasons prevent it.

Recommendation: Health Follow-Up of Isolated Inmates

34. Halden Municipality should ensure daily supervision and follow-up of inmates who are isolated in their cells big parts of the day, including inmates who are isolated by court order or at their own request.
35. Halden Municipality should maintain a systematic overview of all isolated inmates, the reasons for isolation, the duration of isolation, and the negative health effects of isolation.

Recommendation: Professional Independence

36. Halden Municipality should ensure that health personnel in the prison fully uphold their independence and never recommend or approve the prison's use of coercive measures.

Recommendation: Inmates with Particularly Extensive Health and Care Needs

37. The prison and the health department should continuously assess the need for accommodations for inmates with extensive health and care needs to ensure that the accommodations are satisfactory and that continued imprisonment is not irresponsible or degrading.
38. The prison should have its own routines for follow-up in cases where imprisonment appears to be disproportionately burdensome for certain inmates.
39. Halden Municipality, through the prison health service, should have its own routines for follow-up in cases where continued imprisonment is considered medically inadvisable.

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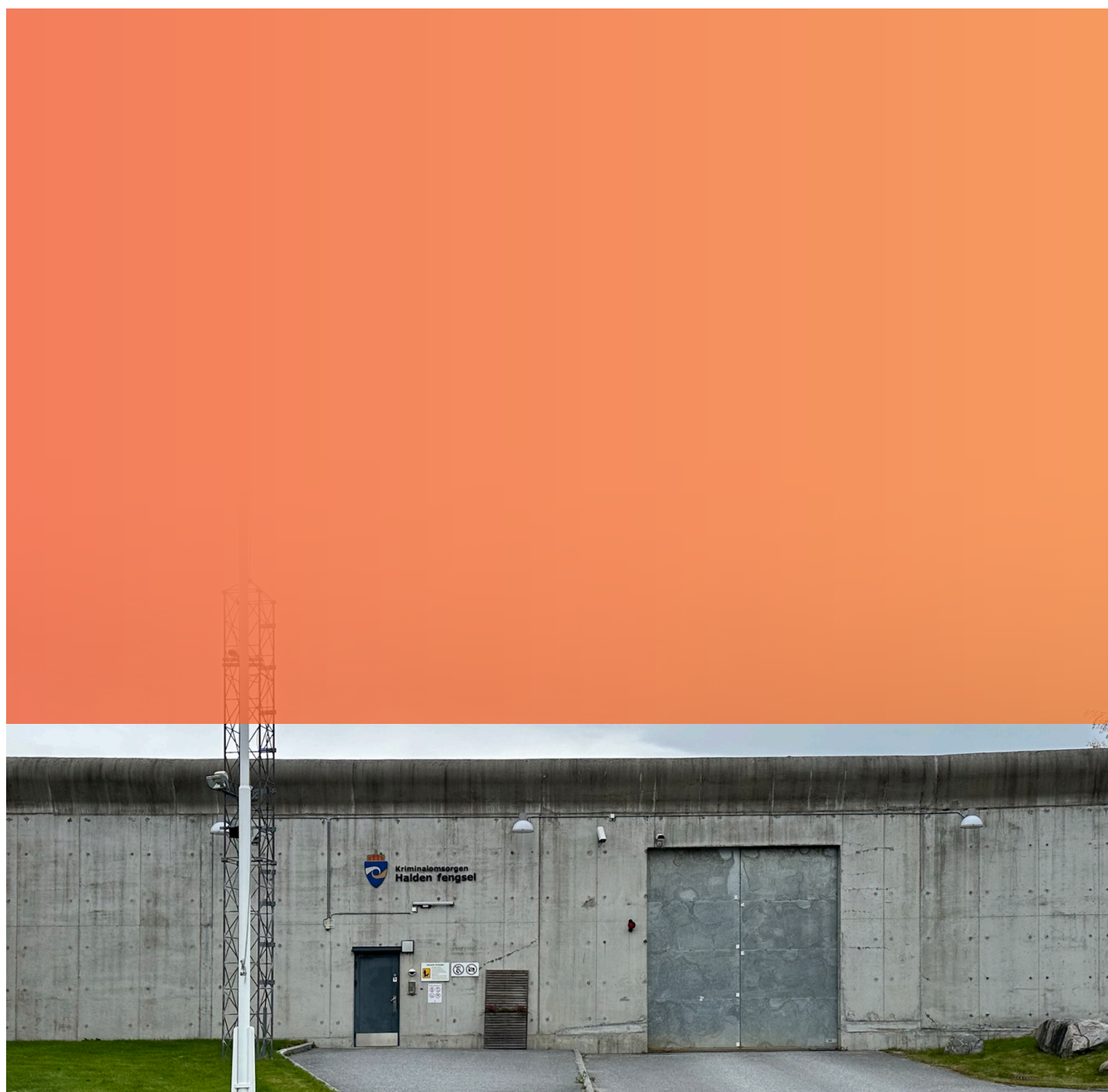


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