SIVILOMBUDET
Norwegian Parliamentary Ombud

VISIT REPORT | no. 81

SUMMARY AND RECOMMENDATIONS

Trondheim prison and preventive detention unit, Nermarka department

March 10th–12th 2024

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.

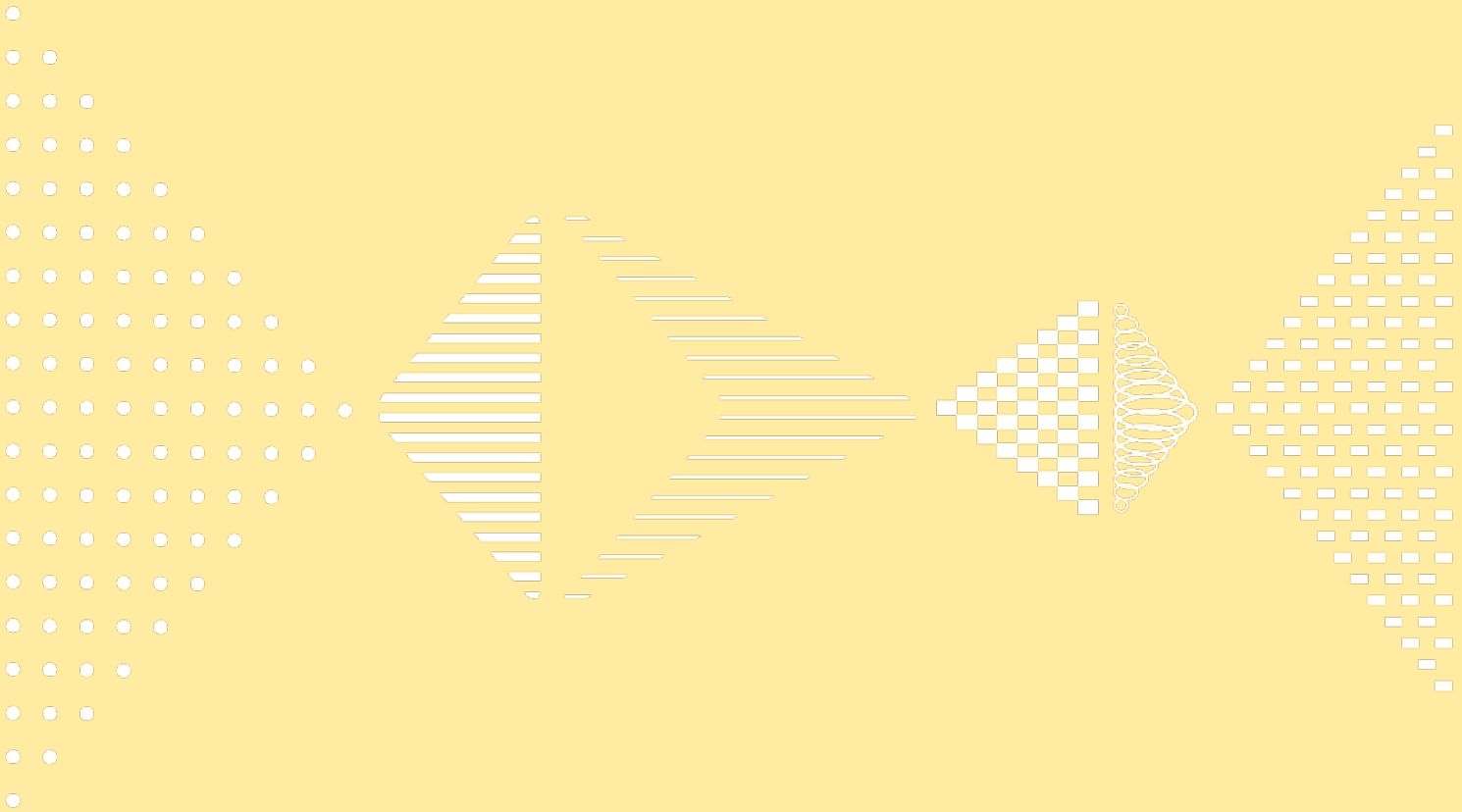
The Parliamentary Ombud's assessments of conditions that pose a risk of torture and inhuman treatment are based on a broad range of sources. During the visits, the national preventive mechanism examines the conditions at the location through observations, interviews and documentation reviews. Private 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 Trondheim Prison (high security) March 10th-12th, 2024. During our visit the prison had 118 cells for men, a unit for female inmates with 11 cells and a unit for preventive detention (“forvaring”) with 10 cells.

Unworthy Sanitary Conditions and Insecurity for Inmates in E-Building
The prison had two communal units with 20 cells per unit in a separate building ("E-building"). Inmates reported not feeling safe in this building. The size of the units led to a lot of noise and unrest. In addition, this made it difficult for the prison staff to identify inmates needing extra follow-up and support. The distance between the guard room and toilet/shower made it difficult for the officers to maintain control in areas that can be unsafe for inmates. The fact that there often was only one officer responsible for supervising the community of 20 inmates made the situation worse. Both interviews and documents indicated that some inmates were being bullied and did not feel welcome in the communal areas. Some felt so unsafe in the E-building that they preferred to stay in the restrictive unit of the prison, even though they were more locked in there and had fewer activity options.

None of the cells in the E-building had toilets or showers. When the inmates were locked in their cells and needed to use the toilet, they had to request permission through the intercom system to be locked out and escorted to the toilet. Inmates reported having to wait for a long time in these situations. Sometimes they had to urinate in the sink in their cells. On weekdays, inmates were locked in their cells without a toilet for 10 hours and 40 minutes at a time, and on weekends, the lock-in period lasted nearly 15 hours.

The unworthy and unsafe conditions in the E-building were pointed out by the Ombudsman after our visit in 2015. The conditions had not improved since then, and especially the hygiene conditions appeared to have deteriorated. The staffing situation also seemed to be worse than it was in our last visit nine years ago. There were plans to renovate the E-building. Even though both the sanitary conditions and safety issues indicated that the size of the units should be reduced and that inmates should have their own bathroom, the renovation plans continued with the same design, keeping 20 inmates per unit with shared toilets and showers.

Challenges in the Unit for Preventive Detention and the Women's Unit
Among other things, the visit revealed that there was little room for individualized adjustments and follow-up for each inmate to ensure progress in their preventive detention sentence. Several inmates called for programs that could contribute to rehabilitation. We also found that several of the staff lacked training in working with preventive detention. A lack of opportunities for progression can increase uncertainty and affect the sense of safety and stability in the unit. It was revealed that several inmates in the detention unit felt unsafe, and some had experienced threats.

Although the women's unit consisted of 11 places, there were only eight available school and work slots for these women. If more women wanted to participate in the only work option for women, the "Creative Workshop," the day was divided so that inmates could only participate for half a day. We found that inmates who wanted to work were hesitant to request it because they knew that other inmates would lose half of their time slots. The work and education offered to female inmates

appeared clearly under-resourced, both in terms of the number of places and the ability to tailor the programs to meet the inmates' varying needs.

Time Outside the Cell and Exclusion from Community with other Inmates

There were significant variations in how long inmates were locked in their cells between the different units. We found that many inmates in several units were not able to spend at least eight hours outside their cells each day, which is the minimum recommended by the European Committee for the Prevention of Torture.

In Unit A1, inmates were locked in their cells for more than 20 hours a day. Nevertheless, the unit was labeled as a communal unit, and inmates in the unit were generally not subject to exclusion decisions. The Ombudsman believes that all inmates in Unit A1, as it appeared during the visit, should have had an exclusion decision for their entire stay there. This also presupposes that the conditions for exclusion must be met.

The number of long-term exclusions from the prison (under the Execution of Sentences Act § 37) was about the same in 2022 and 2023, even though the number of places in the prison was drastically reduced in 2023. Thirteen of the 23 exclusion decisions that lasted more than 14 days in 2023 were based on the inmates' own requests to be excluded. This reinforces the Ombudsman's concern about the conditions in the E-building.

Concerning Use of Security Cells

According to the prison, 20 decisions were made regarding the use of security cells in 2023. Our review showed that 15 of the 20 decisions were triggered by suicide attempts, self-harm, or expressed desires to take one's own life. It is very concerning that security cells are used as a measure to prevent suicide.

In three of the cases we reviewed, inmates’ mattresses were taken away during part of their stay in the security cell. In one of these cases an inmate had the mattress removed throughout the night and into the following day, for a total of 17.5 hours, because he was lying under the mattress. This happened shortly after a suicide attempt. We also saw several examples where inmates in security cells were stripped of their clothes without any specific justification for why it was necessary.

In several of the decisions regarding use of security cells, it was difficult to understand why the prison believed that the use of the security cell was "strictly necessary" in the specific situation. Although some decisions included good descriptions of attempts at dialogue from officers, many of them lacked descriptions of attempts at conflict resolution, conversations, and closer follow-up without the use of restrictive measures. We found no examples where individual vulnerability factors such as high or low age, health challenges, disabilities, background from conflict zones or other traumatic backgrounds, were considered to suggest that the use of security cells would be disproportionate in the situation.

Insufficient Health Assessments

The Ombudsman's visit also revealed several deficiencies in the health assessments of new inmates. We found that one-third of the inmates lacked an assessment of self-harm and suicide risk, which, according to the municipality, was supposed to be conducted by the health department upon intake. We also found deficiencies in the assessment of substance use, addiction, and withdrawal states,

raising concerns that these were not adequately identified. Since substance use is also a known risk factor for suicide, this part of an assessment can be especially important.

Health Follow-up for Isolated Inmates

Our document review showed significant variations in supervision and follow-up by health personnel for inmates who were isolated for several weeks or months. Some received daily supervision from Monday to Friday some weeks, but not every week. Others received varying levels of follow-up from week to week, without any documentation explaining why there was no daily supervision. Four inmates experienced a clear deterioration in both physical and mental health after three to four weeks of isolation, and for three of them, the isolation continued for at least two months. In several of these cases, we missed more systematic and planned collaboration between the prison and healthcare services to end the isolation or prevent further harm.

Risk of Unsafe Medication Handling and Lack of Individual Assessments

During the visit, we observed that inmates' medicine dispensers were openly accessible in the guard room in the E-building. Open and easy access to medications, combined with many staff members always having access to the guard room, increases the risk of medications being lost or misused. We also observed that medicine distribution was done in the communal area with several inmates present. This clearly increases the risk of private health information being exposed and heightens the risk of pressure and threats from inmates seeking access to others' medications.

For patients receiving or starting ADHD medication, the health department had created an "Agreement to Urine Testing," in which the patient committed to two weekly urine tests. A positive urine test or failure to provide a test would result in the patient effectively going without ADHD medication for two months (quarantine period). Several other aspects of the urine test system were problematic, and the health department should review its ADHD medication policy.

III. Recommendations

Demanding Resource Situation

1. The prison should secure better safety for both inmates and staff through increased presence of prison officers.

Unworthy and Unsafe Conditions in E-Building

2. The prison should immediately ensure that all inmates can access toilet facilities in a hygienic and decent manner, whenever necessary.
3. The prison should work to ensure that the units in the E-building have a size and design that facilitates safety and follow-up, and that the cells are equipped with private toilets and showers.

Challenges in the Unit for Preventive Detention

4. The prison should ensure staffing, training, and organization that allow those sentenced to preventive detention to receive relevant content in their sentences and necessary follow-up.

Deficiencies in daily activity for inmates in the Women's Unit

5. The prison should, as far as possible, ensure that all inmates have daily activity in the form of work or education.

Communication and Limited Use of Interpreters

6. The prison should provide an interpreter during intake interviews for all inmates who do not have sufficient language skills. An Interpreter should also be used when important information is to be given or when inmates wish to communicate information to the prison. The offer and use of interpreters should be documented.

Contact with the Outside World

7. The prison should strengthen inmates' opportunities for contact with the outside world. This especially applies to contact with friends and family through phone calls, video calls, and visits.

Prevention of Coercion, Force, and Dissatisfaction

8. The prison should ensure that the first part of the assessment of inmates occurs immediately upon admission.
9. The prison should strengthen its work to prevent isolation and the use of coercive measures. Inmates should be involved in this work.

Suicide Prevention

10. 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.
11. The prison should ensure that isolation is not used to prevent or manage the risk of suicide.

Time Outside the Cell and Exclusion from Community with other Inmates

12. The prison should ensure that all inmates who are not given a formal decision of isolation can spend at least eight hours outside their cells each day and engage in meaningful activities, including on weekends.
13. The prison should strengthen its efforts to reduce the risk of isolation damage and ensure that all isolated inmates have a minimum of two hours of meaningful human contact daily.
14. The prison should immediately ensure that police interrogations are never used as isolation-reducing measures and are not recorded as "meaningful human contact."
15. The prison should ensure that isolated inmates can have access to communication with and follow-up from healthcare personnel.
16. The prison should implement measures to ensure that all decisions regarding isolation (exclusion and security cells) include a specific justification showing that the legal requirements are met. It should always be stated why isolation is strictly necessary.
17. The prison should ensure that the strict necessity of isolation (exclusion and security cells) is continuously assessed, and that these assessments are documented in writing. Isolation must cease as soon as the legal requirements are no longer met.
18. The prison should find a solution for the distribution of food and drink in the security cell that ensures inmates are treated with respect and dignity.
19. The prison should ensure that inmates can wear their own clothes during their stay in the security cell, unless considerations for the inmates' own safety dictate the use of prison clothing.

Organization and Cooperation in Health Follow-Up

20. 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 and poor physical conditions in the prison.

Health Assessment

21. Trondheim Municipality should ensure the assessment and evaluation of health needs upon intake and no later than within 24 hours, even outside of the healthcare department's opening hours. Assessment and evaluation of suicide risk should always be done upon intake.
22. Trondheim Municipality should ensure the assessment of substance abuse issues, including withdrawal states and measurements of vital parameters.
23. Trondheim Municipality should ensure the use of interpreters in conversations with health care personnel where inmates need it.

Contact with Healthcare Services (Communication Slips)

24. The municipality and the prison should together ensure that inmates can contact the healthcare department directly without confidential health information being accessible to unauthorized parties.

Medication Management

25. The prison and the municipality should together ensure a system for proper medication management to strengthen patient safety and prevent the spread of health information.

26. Trondheim Municipality should ensure that no disproportionate measures are taken against patients to document sobriety. The municipality should also prevent the spread of health information.
27. Trondheim Municipality should ensure that patients needing ADHD medication receive the necessary healthcare.

Appointments for Health Services Outside the Prison

28. The prison and the municipality should each keep track of canceled and postponed appointments for health services and work together to ensure that inmates receive necessary healthcare follow-up.
29. The prison and the municipality should together ensure that inmates with appointments in specialist health services are informed of the time of the appointment, unless security reasons prevent this.

Healthcare Follow-Up of Isolated Inmates

30. Trondheim Municipality should ensure daily supervision and follow-up of inmates who are isolated, including on weekends. There must be proper record-keeping of the follow-up.

Inmates with Particularly Extensive Health and Care Needs

31. The prison should have its own procedures for follow-up in cases where a prison stay appears to be disproportionately burdensome for certain inmates.

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