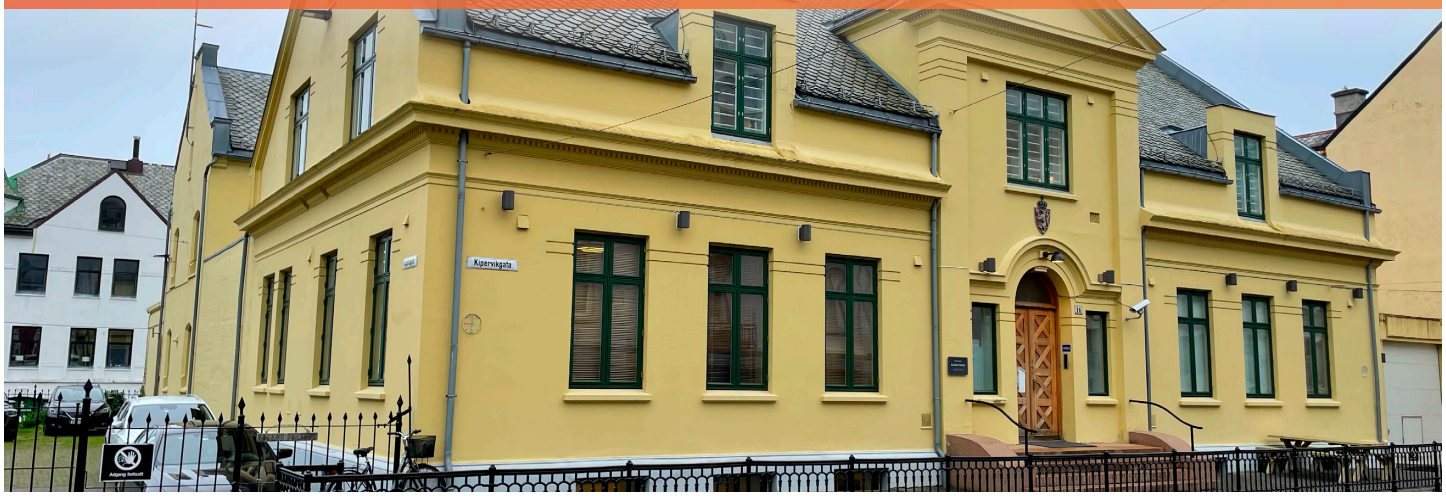
SIVILOMBUDET
Norwegian Parliamentary Ombud

VISIT REPORT | no. 83

SUMMARY AND RECOMMENDATIONS

Ålesund prison

September 3 to 5, 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 National Preventive Mechanism visited Ålesund Prison from September 3 to 5, 2024. Ålesund Prison is a high-security prison for men with 27 places.

Limited time out of cell poses risk of inhuman and degrading treatment

After the visit, the Ombud is seriously concerned about the extensive time that inmates are locked in their cell. The prison's daily schedule resulted in many inmates being systematically locked in their cells for more than 18 hours a day on weekdays. On weekends, almost all inmates were locked in for more than 19 hours. Systematic lock-in of this magnitude, for indefinite periods and without individual assessment, poses a risk of inhuman or degrading treatment.

Inmates with opportunity to work or go to school a full-day were outside their cells more than others, but at the time of the visit, only eight out of 24 inmates had full-day programs. Ten inmates had no job or school offer at all. Several inmates showed signs of distress, and some were clearly harmed by the extensive time spent alone in the prison cell.

Several factors exacerbated the burden on inmates who were being locked in for long periods. Inmates had limited opportunity to socialize with others because the scarce time outside their cells had to be used for practical tasks, such as cooking, showering, exercising, and using the phone. Their contact with the outside world was also limited, as phones could only be used during communal hours, and were positioned in a way that made it impossible to have confidential conversations with friends or family. The outdoor exercise area was critically inadequate, and many inmates did not fully use the outdoor time. Inmates who did not use their outdoor time were locked back in their cells, making the time alone in the cell even longer than the daily schedule indicated. We also found that the food offered to inmates did not meet the guidelines of the Norwegian Directorate of Health, as it was only possible to choose food for breakfast, lunch, and evening meal from a limited list that did not include fruits or vegetables.

There was little awareness among the prison staff that some inmates were locked in their cells for extended periods. The prison did not systematically follow-up all inmates who were locked in for long periods, although we could see that they had implemented some positive measures for individual inmates struggling with isolation.

Neither the prison's health department nor the specialist health services were aware of the prison's daily schedule, nor did they realize how much time the inmates were locked alone in their cells every day. There was a lack of systematic health-promotion work and harm-reducing measures to counter the intrusive lock-in regime, even within the health services. The municipal health service was also understaffed and lacked the capacity to carry out preventive work.

We were concerned by the prison and health services' lack of understanding of the risks associated with the locking regime.

Isolation of inmates should be better assessed, and follow-up of isolated inmates should be documented more clearly

The number of inmates formally excluded from the prison community was low, and the exclusions that were made were generally short-term. However, our review of decisions on exclusion from 2023 and 2024 showed that the written assessment in the decisions often was weak. In several of the

decisions, it was difficult to understand whether the conditions for exclusion had been met. There is a need to improve these assessments, both to ensure that the conditions for exclusion are fulfilled before an inmate is excluded, and so that decisions can be verified.

We also assessed the follow-up of inmates who had been isolated by a court decision for longer periods. The prison seemed to follow up these inmates daily, but it was not possible to determine from the documentation whether the inmates were actually offered two hours of meaningful human contact every day. In several cases, it was unclear whether the inmate had been alone when they were let out of their cells. In the four cases of complete isolation that we reviewed, entries such as "open door," "exercise alone," and "walk in the corridor" were logged as meaningful human contact.

We also found that the health department at the prison generally followed up the inmates who were isolated by the court every day, but that the health department itself did not document this adequately. The health records often lacked information about whether the individual had been isolated by court order, when the isolation started, and how long it was supposed to last. There were also no documented health assessments or descriptions of measures, even when it was noted that inmates were in psychological distress due to the isolation. Such shortcomings could contribute to negative health developments not being detected and addressed promptly.

Work to prevent suicide and self-harm can be improved

The prison assessed the risk of suicide and self-harm upon admission, but we found no systematic follow-up of this assessment later during the prison stay. We also did not find documentation showing that the prison worked systematically to prevent self-harm and suicide throughout the prison stay, even though we saw several individual cases where measures had been taken for inmates at risk of suicide. In three cases, inmates at risk of suicide were excluded and placed in cell 19, a cell the Parliamentary Ombud does not consider suitable for housing someone at risk of suicide.

The prison’s health department only rarely conducted its own assessment of suicide and self-harm risk upon admission, which is clearly reprehensible. We found a few examples where such an assessment was carried out during the prison stay, but we are concerned that the health department can miss out on situations where there is a risk of self-harm or suicide.

III. Recommendations

The healthcare facilities and cooperation between the healthcare services and the correctional services.

1. The prison should ensure that the healthcare services have suitable premises and enough space to adequately address the health needs of the inmates.
2. The municipality, the prison, and the hospital should strengthen their cooperation. This should include regular meetings between the prison and the healthcare staff working within the prison.

Lock-in regime

3. The prison should ensure that all inmates can be outside their cells for at least eight hours every day.
4. The prison should, as far as possible, ensure that all inmates have access to daily activities such as work or education.
5. The prison should ensure that inmates can have confidential contact with the outside world.
6. The prison should ensure that prison officers have the time and ability to follow up with all inmates.
7. The prison should ensure that inmates have access to a yard for outdoor activities, with the opportunity for physical exercise and shelter from the weather.
8. The prison should ensure that the food offered to inmates aligns with the Norwegian Directorate of Health’s dietary guidelines.
9. The prison should strengthen its efforts to reduce the risk of harm caused by isolation.
10. The prison, municipality, and hospital should collaborate to implement health-promoting measures for inmates to prevent and reduce negative health consequences resulting from conditions in the prison.
11. The municipality should ensure that health needs are assessed upon entry, and no later than within 24 hours, even outside the healthcare department's working hours.

Exclusion from the community of other inmates

12. The prison should implement measures to ensure that all decisions on exclusion from community are made in accordance with the law, with a specific assessment showing that the legal conditions are met. It must always be clear why isolation is strictly necessary.

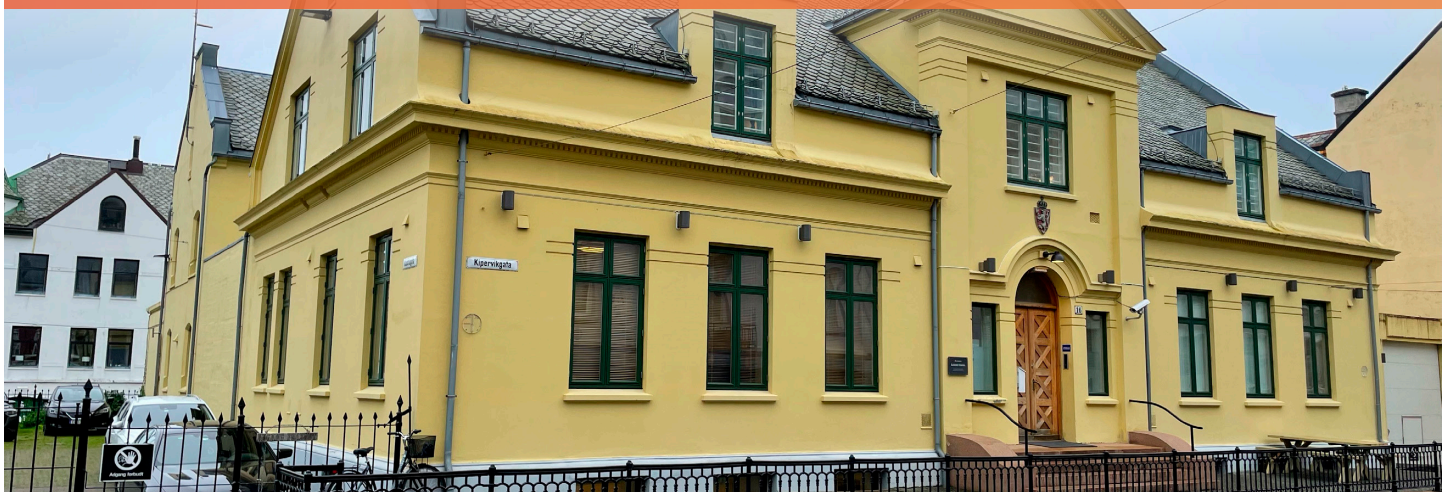
Monitoring of isolated inmates

13. The prison should continue its efforts to ensure that all inmates in isolation receive daily follow-up, with at least two hours of meaningful human contact offered.
14. The municipality should ensure daily supervision and follow-up for inmates who are isolated, and that this is documented in the inmate's medical record.

Prevention of self-harm and suicide

15. The prison should ensure that inmates at increased risk of suicide or self-harm are met with evidence-based preventive measures, such as increased human contact, care, and engagement.
16. The prison should ensure that isolation is not used as a measure to prevent or manage self-harm, suicide attempts, or suicide.
17. The municipality should ensure routine screening and assessment of self-harm and suicide risks upon admission and on an ongoing basis when needed. It should also ensure that this is documented in the medical record.

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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