SIVILOMBUDET
Norwegian Parliamentary Ombud

VISIT REPORT | no. 91

SUMMARY AND RECOMMENDATIONS

The Use of Mechanical Restraints, Sørlandet Hospital

28 – 30 October 2025

National Preventive Mechanism against
Torture and Ill-Treatment

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Norwegian Parliamentary Ombud
National Preventive Mechanism

Visit report

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I. Visit to Sørlandet Hospital – Examination of the Use of Mechanical Restraints

1.1 The Parliamentary Ombud's Mandate to Prevent Torture and Inhuman Treatment

Persons deprived of their liberty are vulnerable to violations of the prohibition against torture and inhuman treatment. The Optional Protocol to the UN Convention against Torture requires States to establish a body tasked with preventing persons deprived of their liberty from being subjected to torture or other cruel, inhuman or degrading treatment or punishment.[1]

In hospital settings, the use of mechanical restraints constitutes a coercive measure that entails a high risk of inhuman or degrading treatment. The National Preventive Mechanism has therefore examined the use of mechanical restraints at selected hospitals.

1.2 The National Preventive Mechanism's Visit to Sørlandet Hospital

By letter of 9 September 2025, Sørlandet Hospital, Division of Mental Health Care, Psychiatric Hospital Department, was notified that the Parliamentary Ombud's National Preventive Mechanism would conduct a visit before the end of 2026. The exact timing of the visit was not specified. The visit was carried out from 28 to 30 October 2025 at the Kristiansand section.[2]

During the visit, we conducted an inspection of the premises and interviews with patients and staff at the hospital. Some interviews were conducted after the visit had concluded. We also obtained extensive documentation from the hospital. A closing meeting with the hospital's management was held on Tuesday 2 December 2025.

1.3 Sørlandet Hospital, Psychiatric Hospital Department, Kristiansand Section

The Psychiatric Hospital Department, Kristiansand section, is located in a new building from 2023 at Eeg in the municipality of Kristiansand, and comprises seven secure inpatient units, each with ten beds. All patients referred to the hospital were admitted via the Psychiatric Emergency Unit, where the average length of stay was just over two days. Patients who were not discharged were transferred to other units, including the Sub-acute Unit, for further assessment and treatment. At the Sub-acute Unit, patients stayed on average for approximately twelve days.

The Psychiatric Emergency Unit, the Sub-acute Unit and one additional unit serve the western part of Agder as their catchment area, while the remaining units serve the entire county.

The National Preventive Mechanism's examination concerned the use of mechanical restraints at the Psychiatric Emergency Unit and the Sub-acute Unit.

[1] The Sivilombud Act, Sections 1, 17, 18 and 19.

[2] The following persons participated in the visit: Helga Fastrup Ervik (Head of Department, lawyer), Solveig Igesund (Deputy Head of Department, social scientist), Johannes Flisnes Nilsen (Special Adviser, lawyer), Mari Dahl Schlanbusch (Senior Adviser, social scientist), Audun Solli (Senior Adviser, social scientist), Tonje Østvold Byhre (Senior Adviser, clinical psychologist), Idunn Lyster (external expert, psychiatrist) and Lars Mathias Enger (Senior Adviser, lawyer).

II. Summary

The use of mechanical restraints, such as being strapped to a restraint bed, carries a high risk of inhuman or degrading treatment. The Parliamentary Ombud's National Preventive Mechanism therefore examined the use of mechanical restraints at the Psychiatric Emergency Unit and the Sub-acute Unit at Sørlandet Hospital, Psychiatric Hospital Department, Kristiansand section, during the period 1 January to 30 October 2025.

Good physical conditions

The hospital had bright and airy premises, with extensive use of wood. In all patient rooms the ceiling height was three metres and large windows admitted natural light. The rooms also contained separate bathrooms with toilet and shower. The units had common areas and an outdoor area with planting, small pathways and several benches to which patients were permitted access. There were dedicated patient rooms adapted for the use of seclusion, with space for staff, windows for observing the patient, and separate outdoor areas at the patient's disposal.

Weaknesses in decisions on the use of mechanical restraints

Interviews and medical records indicated that, as a rule, the hospital used mechanical restraints only when the statutory conditions were met. Nevertheless, we identified certain decisions to use restraints that appeared unlawful, including two decisions in which the justification for using restraints was to prevent a possible future incident.

The law requires that the use of restraints be absolutely necessary. Many decisions contained justifications that made it difficult to understand that this requirement had been met. This included decisions with very general descriptions of the patient's behavior or that did not describe concrete attempts to use less intrusive measures. In many cases it was also unclear whether the patient had been strapped to a bed or fitted with mobile restraints. Almost no decisions described whether the patient was particularly vulnerable due to age, previous trauma or other circumstances that could increase the burden of being placed in restraints.

Our findings also showed that the hospital should strengthen the involvement of the responsible clinician in decisions on the use of mechanical restraints.

Risk of patients being kept in restraints for too long

Many patients were restrained for extended periods of time, in four cases for more than twenty-four hours. The hospital often did not adequately describe why the conditions for the use of mechanical restraints continued to be met throughout the period of restraint. Very long intervals could elapse between each assessment documented by the hospital, and descriptions of the patient and the situation were also frequently absent. This was the case with an 18-year-old woman who was restrained for seven hours without anything being recorded about the situation after the restraints were applied. Furthermore, there were several instances in which the patient slept for many hours without the hospital recording any explanation of why the restraints could not be removed. These deficiencies are serious, and information in the medical records indicates that certain patients were kept in restraints unlawfully long.

We also found that staff held differing views as to who could decide that a patient be fully or partially released from restraints. Uncertainty about this division of responsibility may entail a risk of patients being kept in restraints for too long.

In one instance, after 18 hours in restraints, a patient was able to speak with a physician who was proficient in the patient's native language, and the patient was then removed from restraints. Although the hospital recorded that this patient spoke very limited Norwegian and English, no interpreter was used.

The involvement of the police in particular

The police were frequently present in connection with patients being restrained upon admission, but the role of the police following arrival at the hospital was generally not described. Furthermore, the reasons for which the hospital contacted the police for assistance in managing a patient were not described with sufficient clarity, and the Parliamentary Ombud is particularly critical of the fact that, in at least two cases, the police assisted in placing patients in restraints.

Prevention

In efforts to prevent the use of coercion, management's knowledge of and attitudes towards the hospital's use of coercive measures are important. Several staff members described management as being focused on reducing the use of coercion, and we also got the impression that hospital management used statistics to monitor the use of mechanical restraints. The hospital's internal records for the period 2022 to 2025 also indicated that the total use of restraints at the two units had decreased during this period.

At the same time, there was no system to ensure that incidents leading to the use of restraints were reviewed by staff in order to learn from the incident and provide a basis for assessing whether the use of coercion could have been avoided. As part of prevention efforts, the hospital should also strengthen the conduct of follow-up conversations with patients after the use of mechanical restraints and ensure a system by which information from such conversations can be drawn upon in future incidents.

Need for strengthened self-oversight by the Supervisory Commission

Patients may appeal against decisions on mechanical restraints to the Supervisory Commission. One appeal decision issued by the commission during the period under examination addressed both the conditions for restraint and the question of the duration of placement in a satisfactory manner. The Commission is also required, on its own initiative, to review all decisions on mechanical restraints. Our review showed that this oversight could have been more thorough, and more consistent with the Commission's sound assessments as reflected in the appeal decision received. The fact that very few patients appeal against restraint decisions underscores the importance of the Commission's self-oversight.

III. Recommendations

Decisions to Use Mechanical Restraints

1. The hospital must ensure that mechanical restraints are used only where the measure is strictly necessary, less intrusive measures have been attempted or considered, and the intervention is proportionate in relation to the patient.
2. The written decision should always specify whether the patient is restrained in a restraint bed or with mobile restraints.
3. The hospital should provide reasons for, and describe, the presence of the police at the hospital. The police should not be involved in the use of mechanical restraints on patients.
4. The hospital should strengthen the supervision exercised by responsible clinicians over decisions to use mechanical restraints.

Treatment and Care of Patients Subjected to Mechanical Restraints

5. The hospital should ensure that matters of significance for the care of patients subjected to mechanical restraints are recorded on an ongoing basis in the medical records.
6. The hospital should ensure that staff work systematically to establish dialogue with the patient in order to minimise the duration of restraint, and that interpreters are used where necessary to ensure effective communication between the patient and staff.
7. The hospital must ensure that the use of mechanical restraints is terminated immediately when the legal conditions are no longer met.

Assessment of the Continuation or Termination of Restraint

8. The hospital should ensure that the use of mechanical restraints is subject to continuous assessment, and that such assessments are documented.
9. The hospital should ensure clear procedures for determining who may decide that a patient is to be fully or partially released from restraints, and that these procedures are known to staff.

Prevention of the Use of Mechanical Restraints

10. The hospital should continue its efforts to prevent the use of mechanical restraints, including strengthened internal control and internal reviews of incidents leading to the use of coercion.
11. The hospital should always offer patients at least one consultation to review the use of mechanical restraints and ensure that relevant information is used systematically to prevent the use of coercion.

Complaints and Oversight

12. The Supervisory Commission should strengthen its routine review of the hospital's use of mechanical restraints.

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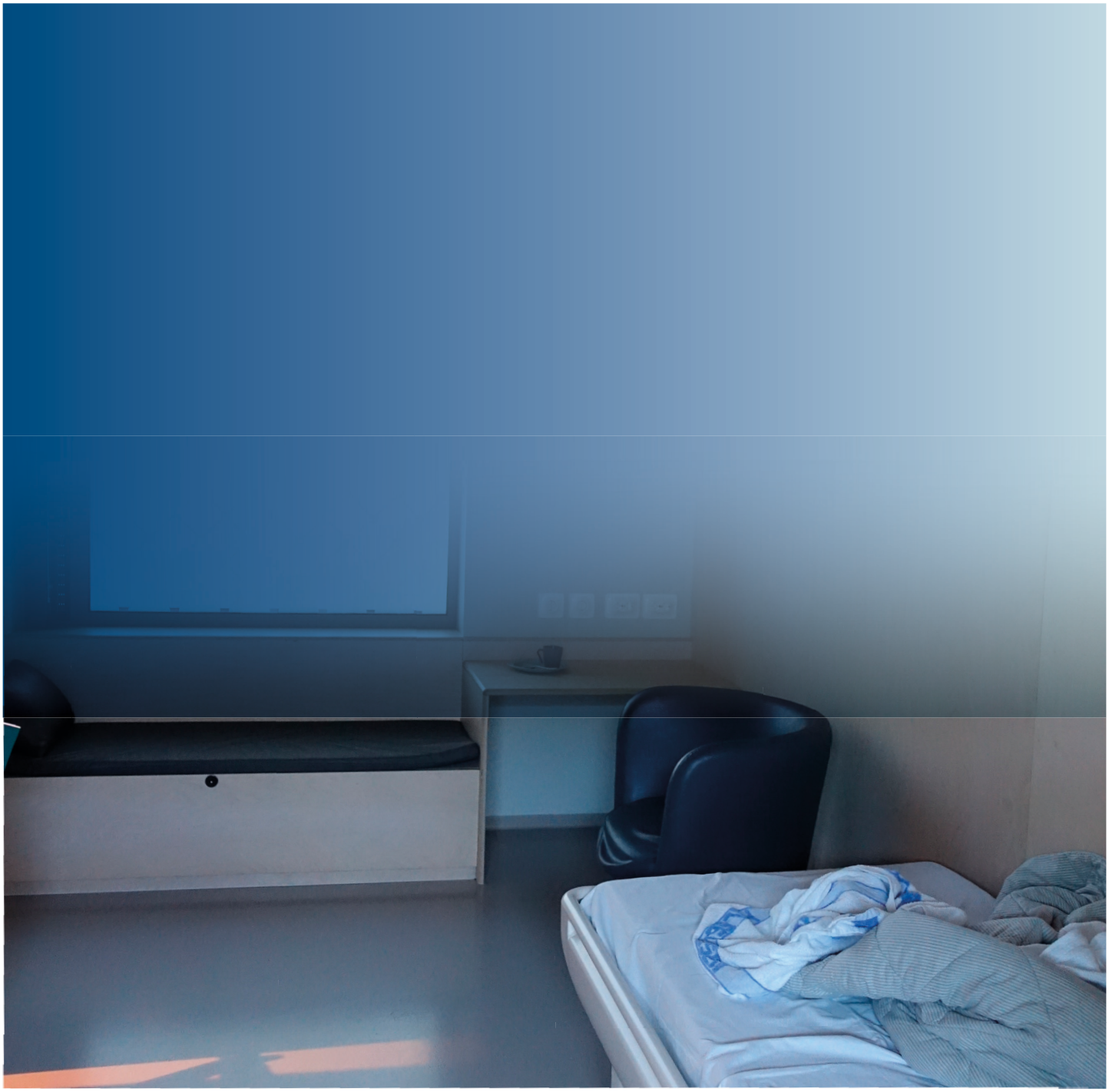

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