SIVILOMBUDET

Norwegian Parliamentary Ombud

VISIT REPORT | no. 92

SUMMARY AND RECOMMENDATIONS

The Use of Mechanical Restraints Vestfold Hospital

10 – 12 November 2025

National Preventive Mechanism against
Torture and Ill-Treatment

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Norwegian Parliamentary Ombud
National Preventive Mechanism

Visit report

Vestfold Hospital

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I. Visit to Vestfold Hospital – investigation into the use of mechanical restraints.

The Parliamentary Ombud's mandate to prevent torture and inhuman treatment

People who are deprived of their liberty are vulnerable to violations of the prohibition against torture and inhuman treatment. The Optional Protocol to the United Nations Convention against Torture requires states to establish a body to prevent persons deprived of their liberty from being subjected to torture and other cruel, inhuman or degrading treatment or punishment. This task is carried out by the Parliamentary Ombud's Preventive Mechanism.[1]

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

The Preventive Mechanism's visit to Vestfold Hospital

By letter of 9 September 2025, the Psychiatric Hospital Department at Vestfold Hospital was notified that the Parliamentary Ombud's Preventive Mechanism would conduct a visit before the end of 2026. The exact date of the visit was not disclosed. The visit was carried out from 10 to 12 November 2025. The subject of the visit was the hospital's use of mechanical restraints (belts) during the period from 1 January to 10 November 2025.[2] We visited three units: the psychiatric emergency unit and wards A and C. During the visit, we conducted inspections and interviews with patients and staff at the hospital. Some interviews were conducted after the visit had been completed. We also obtained extensive documentation from the hospital. A concluding meeting with the hospital management was held on Thursday 11 December 2025.

Vestfold Hospital, Psychiatric Hospital Department

The Psychiatric Hospital Department at Vestfold Hospital is located in a new building from 2019 on the hospital site in Tønsberg and at Granli near Sem (security and long-term wards). The department has seven inpatient wards, each with 10 or 12 beds, with somewhat fewer beds in the long-term wards. All patients referred to the department were admitted through the psychiatric emergency unit, where the average length of stay for patients was approximately 1.5 days. Wards A and C were acute wards whose primary function was to assess, diagnose and initiate treatment. The department's catchment area is Vestfold county, with the exception of parts of Holmestrand municipality.

The Preventive Mechanism's investigations concerned the use of mechanical restraints at the psychiatric emergency unit and wards A and C.

[1] The Parliamentary Ombud Act sections 1, 17, 18 and 19.
[2] Those who participated in the visit were Solveig Igesund (Assistant Head of Department, social scientist), Johannes Flisnes Nilsen (Special Adviser, lawyer), Mari Dahl Schlanbusch (Senior Adviser, social scientist), Ida Giske (Senior Adviser, social scientist), Tonje Østvold Byhre (Senior Adviser, specialist psychologist), Inga Tollefsen Laupstad (Senior Adviser, lawyer), Lars Mathias Enger (Senior Adviser, lawyer) and Erlend Strand Gardsjord (external expert, psychiatrist).

II. Summary

The use of mechanical restraints, such as being strapped into a restraint bed, entails a high risk of inhuman or degrading treatment. The Parliamentary Ombud's Preventive Mechanism has therefore examined the use of mechanical restraints at the psychiatric emergency unit, ward A and ward C at the Psychiatric Hospital Department, Vestfold Hospital, during the period from 1 January to 12 November 2025.

Good physical conditions

The Psychiatric Hospital Department moved into a new building in 2019. The premises were large, bright and modern, with wide corridors and large windows. Several people highlighted the new premises and good maintenance as contributing positively to the wellbeing of both staff and patients. Patients also had access to well-maintained outdoor areas.

Weaknesses in decisions on the use of mechanical restraints

The law requires the use of belts to be strictly necessary. Staff appeared to have a conscious awareness of the high threshold for when belts may be used. Nevertheless, many decisions contained unclear reasoning, making it difficult to assess whether the restraints met the legal conditions. The reasoning often contained vague descriptions of the patient's behaviour and only general references to less intrusive measures.

Two restraints appeared to have been justified for preventive purposes without there being an acute dangerous situation. The written decisions very rarely described whether the patients were particularly vulnerable due to trauma, age or similar factors that could increase the burden of being placed in restraints.

Most restraint decisions were made by the staff member in charge of the ward in situations where the clinically responsible person (consultant psychiatrist/specialist psychologist) was not present. The clinically responsible persons generally did not take a position on whether the restraints should continue, as required by the regulations. The clinically responsible person has an important role in quality assuring such decisions. Failure to carry out assessments may contribute to patients remaining in restraints longer than permitted by law.

Care of patients in restraints

Mechanical restraints must be carried out as gently as possible. However, the documentation made it difficult to obtain a clear picture of how patients were cared for during restraint. Descriptions of observations, assessments and measures varied. Dialogue with the patient and information about food and fluid intake were not documented systematically, even in restraints lasting more than 24 hours.

Medical supervision was generally carried out at least every eight hours. In several cases, however, several hours passed between the restraint and the first medical supervision. This is contrary to human rights recommendations stating that a doctor should examine restrained patients as soon as possible after the measure has been initiated.

Where restraints are used for more than eight hours, they must, as far as possible, be adjusted or partially loosened. In two cases, the documentation indicated that patients had remained fully restrained for around twelve hours without any relief or change of position, without the reason for this being stated.

In some cases, staff held a towel in front of a patient's face when the patient spat, and in one medical record a patient described that a tight towel had been placed over their mouth. The Ombud strongly advises against this, because it may be frightening and entails a risk of obstructing the airways.

Risk of patients remaining in restraints for too long

Many patients were restrained for long periods, in several cases for several days. One patient was restrained for more than 18 days. All the conditions for the use of mechanical restraints must be met for as long as the restraint continues, and the need must be continuously assessed and documented.

We found very few descriptions of why the conditions were met during the restraints. Descriptions of the patients' behaviour and the assessments of this behaviour were often highly inadequate, and in several cases the documentation indicated that the continued restraint was unlawful. For example, one patient was described over a period of eleven hours as either asleep or cooperative without it being stated whether ending the restraint had been considered. Another patient was restrained for around two days before the patient's behaviour and need for restraints were assessed again.

We also found several examples of patients sleeping in restraints without attempts being made to release them, even when they slept for extended periods. Restraining sleeping patients can easily conflict with the strict legal conditions.

The hospital's failure to assess the basis for continued use of mechanical restraints constitutes a serious failure of legal safeguards.

Prevention of mechanical restraints

The management appeared proactive in its work to prevent the use of coercive measures. At the same time, findings concerning weakly reasoned decisions and lack of reasoning for continued restraints showed that there is a need to strengthen the preventive work. Areas for improvement particularly concerned training of decision-makers, compliance with the requirement to offer follow-up conversations to patients after the use of coercion, and systematic use of incident reviews for staff.

Need for strengthened oversight by the Supervisory Commission

Patients may complain to the Supervisory Commission about decisions concerning mechanical restraints. Several of the Commission's reviews of complaints appeared to involve insufficiently thorough scrutiny of whether the conditions had been met throughout the entire period of restraint.

Because few patients complain about decisions concerning mechanical restraints, the Commission's own investigations are central to safeguarding patients' legal protection and uncovering prolonged or excessive use of restraints. In very few cases had the Commission made comments regarding the content of the decision or the duration of the restraint in the ten longest restraints from our investigation period. This includes decisions and courses of events whose lawfulness the Parliamentary Ombud has questioned, and gives cause for concern about the quality of the oversight.

III. Recommendations

Decision to use mechanical restraints

1. The hospital must ensure that mechanical restraints are used only when 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 decision should always state whether the patient is restrained in a restraint bed or in transport restraints/mobile restraints.
3. The hospital should justify and describe the presence of the police at the hospital. The police should not participate in placing patients in mechanical restraints.
4. The hospital should strengthen the clinically responsible persons' review of decisions concerning mechanical restraints.

Care of patients in restraints

5. The hospital should continuously record in the medical records matters relevant to the care of patients subjected to mechanical restraints.
6. The hospital should ensure that restrained patients are always examined by a doctor as soon as possible, and thereafter at short intervals until the measure is discontinued.
7. Covering the mouth or face of restrained patients should not occur.

Assessment of continuation or discontinuation of restraintions

8. The hospital must ensure that the use of mechanical restraints is discontinued immediately when the legal conditions are no longer met.
9. The hospital should ensure that the use of mechanical restraints is continuously assessed and that the assessments are documented.
10. The hospital should engage in dialogue with staff on measures to avoid patients sleeping in

Prevention of mechanical restraints

11. The hospital should continue its work to prevent the use of mechanical restraints, including strengthened internal control and training.
12. The hospital should always offer patients at least one conversation to evaluate the use of mechanical restraints, and ensure that relevant information is used systematically to prevent the use of coercion.

Complaints and oversight

13. The Supervisory Commission should strengthen its handling of complaints concerning mechanical restraints, particularly the review of the duration of restraints.
14. The Supervisory Commission should strengthen its routine review of the hospital's use of mechanical restraints.The hospital should continue its work to prevent the use of mechanical restraints, including strengthened internal control and training.

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