



SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

ANNUAL REPORT 2017

DOCUMENT 4:1 (2017–2018)

**National Preventive Mechanism against Torture and Other Cruel,
Inhuman or Degrading Treatment or Punishment**

Which sectors are covered by the NPM's mandate?



65

**PRISONS AND
TRANSITIONAL
HOUSING**

approx.

130



**POLICE CUSTODY FACILITIES
AND PLACES WITH INTERROGATION
ROOMS**

This number is an estimate. The ongoing police reform is likely going to affect this number in the coming years.



approx.

20

**CUSTOMS AND
EXCISE'S DETENTION
PREMISES**

1

**INVOLUNTARY
INSTITUTIONAL
TREATMENT
(BRØSET)**



**HOUSING FOR PEOPLE
WITH DEVELOPMENTAL
DISABILITIES**

With respect to places of detention for people with developmental disabilities, this figure is uncertain, among other things because many of them live in their own homes and in sheltered housing. The NPM has yet to carry out visits to such places and has therefore not finished mapping this sector.

9

**THE NORWEGIAN
ARMED FORCES'
CUSTODY
FACILITIES**



17



**INSTITUTIONS FOR INVOLUNTARY
TREATMENT OF PEOPLE WITH SUBSTANCE
ABUSE PROBLEMS**



approx.

1,000

NURSING HOMES

1

**THE POLICE
IMMIGRATION
DETENTION CENTRE
(TRANDUM)**



approx.

120

**MENTAL HEALTH CARE
INSTITUTIONS**



**CHILD WELFARE
INSTITUTIONS**

approx.

150

Document 4:1 (2017–2018)

**The Parliamentary Ombudsman's Annual Report for 2017
as National Preventive Mechanism against Torture and Other Cruel,
Inhuman or Degrading Treatment or Punishment**

Submitted to the Storting on 20 March 2018

Foreword

The year 2017 was another busy year for the Parliamentary Ombudsman's prevention work. Thirteen visits were made to places of detention in four sectors. The Ombudsman highlighted a number of risk factors for violations and some matters that gave great cause for concern. However, we also find good practices at a number of the places we visit.

In December 2016, we published our first thematic report under the prevention mandate. The report, entitled 'Women in Prison', identified several conditions that lead to women serving under poorer conditions than men. There has been a great deal of interest in this topic in Norway in 2017. The Correctional Service has adopted a new strategy for women remanded in custody and serving sentences in the period 2017–2020, with the aim of ensuring that women serve under the same conditions as men. We had the opportunity to discuss this and other topics at the Correctional Service's conference for heads of units.

In November 2017, the UN Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) raised the thematic report's findings during its examination of Norway in Geneva. In its recommendations, the Committee expressed concern about the prison conditions for women in Norway, and recommended that efforts be stepped up to improve the prison conditions and health services for female inmates. The Norwegian authorities have two years to follow up the recommendations.

The report from the Parliamentary Ombudsman's visit to Norgerhaven Prison in the Netherlands was published in March 2017. Since autumn 2015, the Norwegian authorities have rented the 242 places at Norgerhaven Prison from the Dutch authorities. After the visit, the Ombudsman pointed out that the serving of sentences in the Netherlands constitutes a breach of Norway's human rights obligations under the UN Convention against Torture. It emerged during the visit that, pursuant to the lease agreement, the Norwegian authorities are not entitled to initiate a police

investigation in the event of a suspected violation of the prohibition against torture and ill-treatment in Norgerhaven Prison. The Ombudsman has pointed out that the execution of sentences in another state does not exempt Norway from its responsibility for human rights violations.

In March, another visit was also made to the police immigration detention centre at Trandum, with a particular focus on its security section. The report highlighted the security section's alarming use of isolation as a means of dealing with vulnerable people who have tried to commit suicide or have expressed an intention to do so. Minors have also been placed in this section, including in a security cell. The way in which this section is used may be harmful to health, and dealing with ill and vulnerable people in this manner is problematic. In their follow-up, the police have stated that they have no other means of addressing the needs of this group. Isolation can be harmful to health, particularly the health of persons who are already vulnerable. The use of isolation as a means of dealing with ill and vulnerable people is serious and constitutes a violation of human rights standards. The Ombudsman will follow this up in its ongoing dialogue with central government authorities.

After its visit to Trandum in 2015, the Ombudsman pointed out that Trandum was not a suitable place for children. We are therefore satisfied that it in 2017 became clear that children shall no longer be detained at Trandum. To the extent that children should be deprived of their liberty at all, it must take place in a more suitable place that is less prison-like and where they are shielded from airport noise. All deprivation

of children's liberty, however, entails an increased risk of torture and ill-treatment, and the Ombudsman will closely follow the development of this practice.

In the field of child welfare, we have continued to visit state-owned emergency institutions and have also expanded our visits to include visits to institutions for long-term substance abuse treatment. We visited both a non-profit and a private institution. Worrying findings included young people being subjected to an alarming amount of pressure through one institution's use of involuntary trips alone with staff. The use of isolation and isolation-like methods will be a focus during visits to child welfare institutions in 2018.

With respect to mental health care, we have visited emergency psychiatry wards at four hospitals. Two of the thematic articles in this annual report concern topics that have been a particular focus: the use of electroconvulsive therapy (ECT) on grounds of necessity, and the use of segregation.

The third thematic article in this annual report concerns isolation in Norwegian prisons. Isolation has long been a challenge in the Norwegian Correctional Service. Worrying findings emerged during several visits to prisons in 2017 relating to the conditions for inmates who are held in isolation. This is an area we want to examine more closely in the coming year.

However, the Parliamentary Ombudsman also identifies good practices during its visits. In our reports, we try to highlight practices that appear to reduce risk and that strengthen the rights of those deprived of their liberty. We also note that a number of supervisory bodies use the Ombudsman's findings and recommendations in their work.

The topic of the Parliamentary Ombudsman's 2017 human rights seminar was: 'The role of health personnel in relation to people deprived of their liberty in police custody facilities and prisons.' Around 200 people from the Correctional Service, the health sector, the police and other relevant parts of the public administration attended the seminar, as well as experts in the field and voluntary organisations. The seminar

was opened by Norwegian and international experts, and three panel discussions were held in which various parties discussed the ethics, principles and practical challenges of work on ensuring that inmates and detainees receive the healthcare they are entitled to.

The European Committee for the Prevention of Torture (CPT) has announced that it will visit Norway in 2018. Norway will also be examined by the UN Committee against Torture in Geneva in April 2018. The Parliamentary Ombudsman will provide information and input to both bodies, and looks forward to Norway being in the international spotlight in this field in the coming year.

Aage Thor Falkanger
Parliamentary Ombudsman

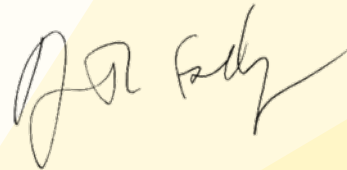




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The Parliamentary Ombudsman's preventive mandate

On 14 May 2013, the Norwegian Parliament, the Storting, voted in favour of Norway ratifying the Optional Protocol to the Convention against Torture, abbreviated OPCAT. The Storting tasked the Parliamentary Ombudsman with exercising the mandate set out in OPCAT, and the National Preventive Mechanism (NPM) was established in 2014 as a department under the Parliamentary Ombudsman to address this area of the Ombudsman's work.

The Parliamentary Ombudsman, represented by the NPM, makes regular visits to places where people are deprived of their liberty, such as prisons, police custody facilities, mental health care institutions and child welfare institutions. The visits can be announced or unannounced.

The Parliamentary Ombudsman has right of access to all places of detention and the right to speak privately with people who have been deprived of their liberty. The Ombudsman also has right of access to all necessary information that is relevant to the conditions for people deprived of their liberty.

During its visits, the NPM will endeavour to identify risk factors for violations by making its own observations and through interviews with the people involved. Interviews with people deprived of their liberty are given special priority.

As part of its prevention efforts, the Parliamentary Ombudsman engages in extensive dialogue with national authorities, control and supervisory bodies in the public administration, other ombudsmen, civil society, preventive mechanisms in other countries and international organisations in the human rights field.

An advisory committee has been established that contributes expertise, information, advice and input to the prevention work.

The UN Convention against Torture

The UN Convention against Torture states that torture and ill-treatment are strictly prohibited and that no exceptions can be made from this prohibition under any circumstances. States that endorse the convention are obliged to prohibit, prevent and punish all use of torture and other cruel, inhuman or degrading treatment or punishment. According to the Convention, each State party shall 'ensure that its competent authorities proceed to a prompt and impartial investigation, wherever there is reasonable ground to believe that an act of torture [or other cruel, inhuman or degrading treatment or punishment] has been committed in any territory under its jurisdiction'.¹

Norway endorsed the Convention against Torture in 1986. The Prohibition against Torture is set out in various parts of Norwegian legislation, including Article 93 of the Norwegian Constitution.

The UN Convention against Torture states that torture and ill-treatment are strictly prohibited and that no exceptions can be made from this prohibition under any circumstances.

¹ See the UN Convention against Torture Article 12.

The Optional Protocol to the Convention against Torture (OPCAT)

The Optional Protocol to the UN Convention against Torture was adopted by the UN General Assembly in 2002, and entered into force in 2006. Its objective is to protect people who are deprived of their liberty. People who are deprived of their liberty find themselves in a particularly vulnerable situation, and face an increased risk of torture and other cruel, inhuman or degrading treatment or punishment.

The background to the Optional Protocol was a desire to increase efforts to combat and prevent torture and ill-treatment. OPCAT therefore stipulates new work methods to strengthen these efforts.

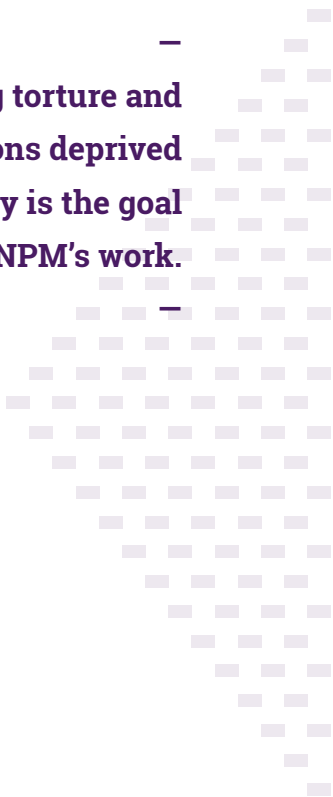
States that endorse the Optional Protocol are obliged to establish or appoint one or several national preventive mechanisms to regularly carry out visits to places where people are, or may be, deprived of their liberty, in order to strengthen their protection against torture and ill-treatment.

The national preventive mechanisms have the possibility to make recommendations that highlight risk factors for violations of integrity. They can also submit proposals and comments concerning existing or draft legislation.

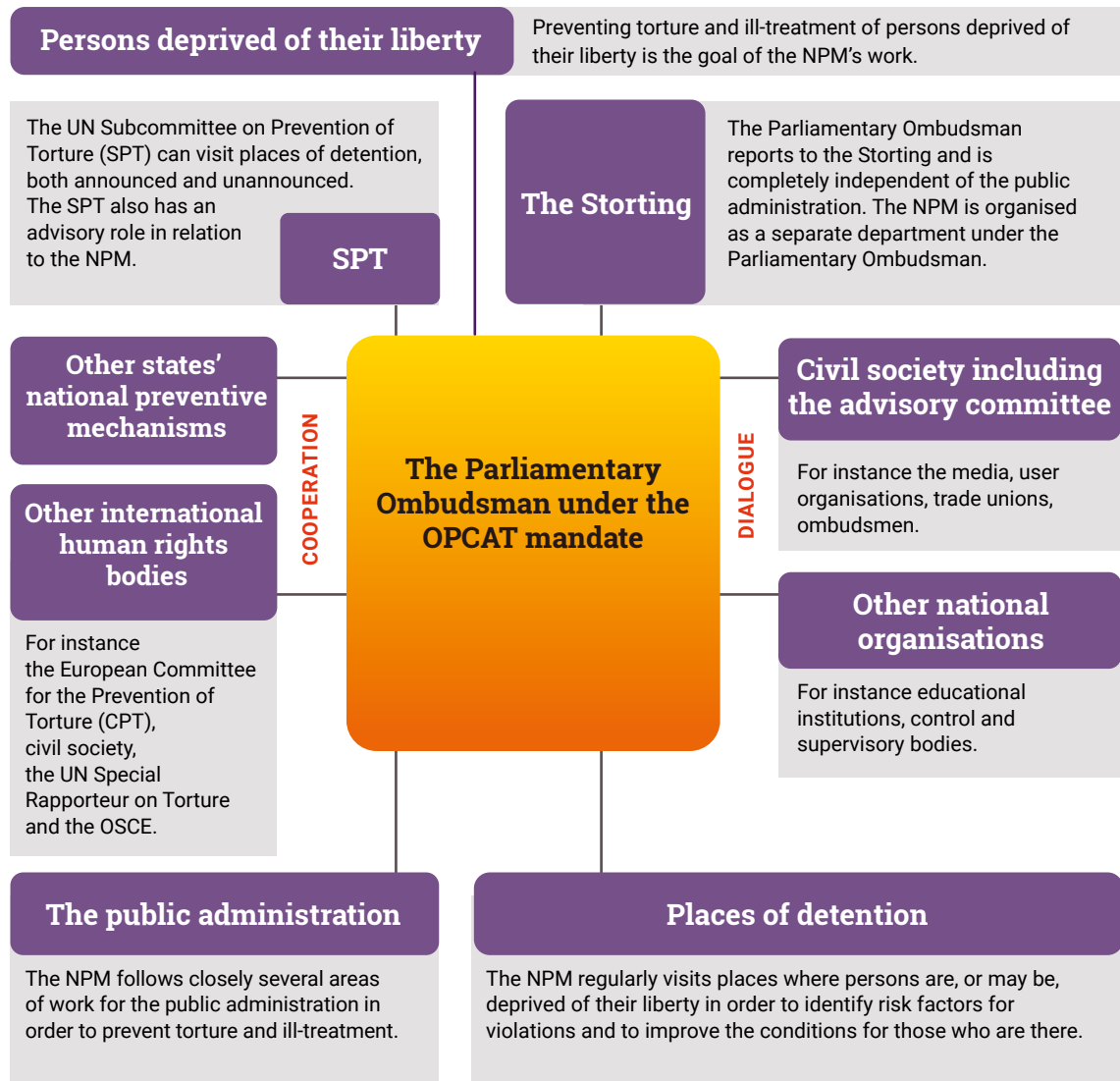
The preventive mechanisms must be independent of the authorities and places of detention, have the resources they require at their disposal and have employees with the necessary competence and expertise.

The Optional Protocol also established an international prevention committee that works in parallel with the national preventive mechanisms, the UN Subcommittee on the Prevention of Torture (SPT). The SPT can visit all places of detention in the states that have endorsed the Optional Protocol. The SPT's mandate also includes providing advice and guidance to the national preventive mechanisms.

**Preventing torture and
ill-treatment of persons deprived
of their liberty is the goal
of the NPM's work.**



The NPM's most important relations





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Working method and organisation

Under its prevention mandate, the Parliamentary Ombudsman has a right to visit all places where anyone is, or could be, deprived of their liberty. This includes public and private institutions and facilities.

The Parliamentary Ombudsman is not a supervisory body, however. All of the sectors where the Parliamentary Ombudsman conducts visits have dedicated bodies that are responsible for their ongoing supervision. The National Preventive Mechanism (NPM) is in dialogue with these bodies in connection with its visits.

Announcement of visits

As a rule, the places we visit are not informed about the dates of the visit. Before a visit, they are notified by a phone call and letter that a visit will take place within a period of two to four months. They are also asked to submit some information prior to the visit.

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In 2017, the NPM carried out four visits to child welfare institutions. Special information materials have been developed for these visits. The Parliamentary Ombudsman also has a dedicated website aimed at children and young people.

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This work method makes it possible for the NPM to obtain relevant information before a visit, while also gaining a realistic impression of the conditions there. In 2017, all visits, except one, were announced in this manner. An unannounced visit was made to the police immigration detention centre at Trandum.

Planning visits

Obtaining information from a number of sources is the first step when planning all visits; from the place to be visited, the supervisory authorities, official authorities and other relevant bodies. The Ombudsman has right of access to information that is relevant to the conditions in places where people are deprived of their liberty. In some cases, the Ombudsman may already have received information from various sources.

Every visit is planned individually. How many people take part in a visit, the duration of a visit and the organisation of the visit team varies depending on, among other things, which sector we are visiting and how big the institution is. It is important to ensure that the visit team are there when the people deprived of their liberty are also there so that they have an opportunity to talk to the team. Visits are always planned with a high degree of flexibility.



During visits

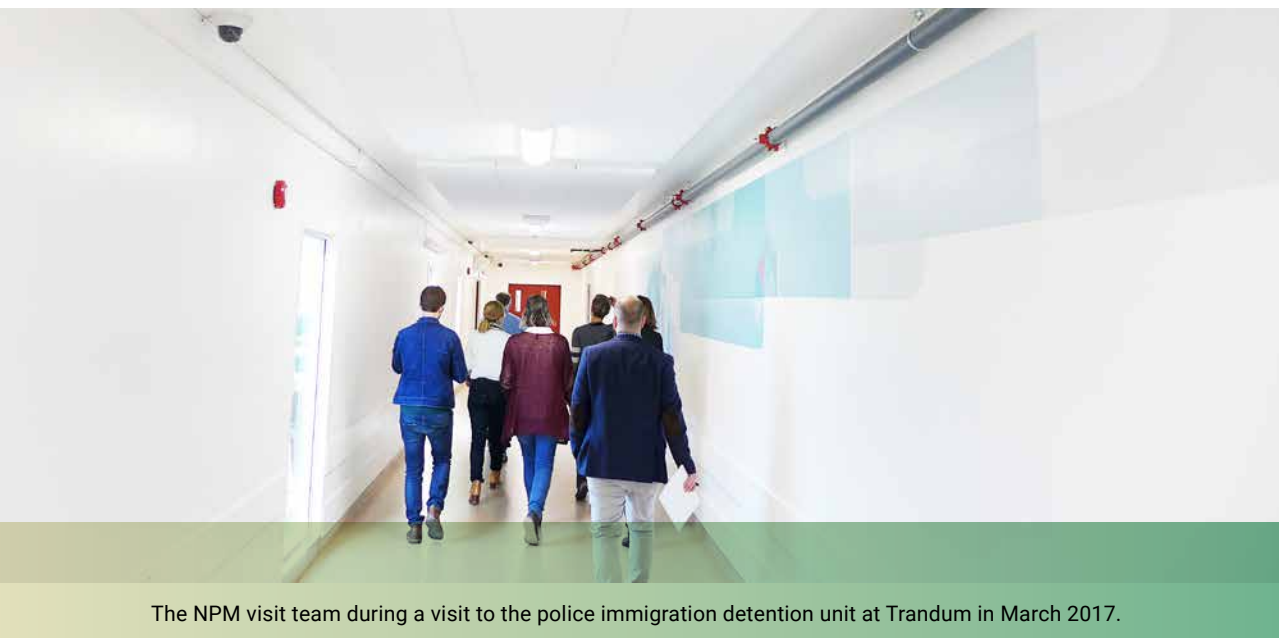
During the visits, the conditions are examined through observations, interviews and a review of documentation. The NPM's main focus is always on conducting private interviews with the persons who have been deprived of their liberty. These interviews are a particularly important source of information, because the people deprived of their liberty have first-hand knowledge of the conditions. They are in a particularly vulnerable situation and have a special need for protection. Their experiences are an important and relevant source of information. Interpreters are used as required.

Interviews are also conducted with the staff, management, health services and other relevant parties. Documentation is also obtained to demonstrate the conditions at the institution, such as routines and procedures, local guidelines, administrative decisions on the use of force, logs, plans and health documentation. The NPM focuses on obtaining information by different means from a number of sources.

The NPM prepares adapted interview guides for the different groups to be interviewed during a visit. All the conversations take place in the form of partly structured interviews.

After visits

A report is written after each visit. The report describes the findings and risk factors identified during the visit. On the basis of these findings, the Ombudsman issues recommendations to the institutions that aim to reduce the risk of people deprived of their liberty being subjected to torture or other cruel, inhuman or degrading treatment or punishment.



The NPM visit team during a visit to the police immigration detention unit at Trandum in March 2017.

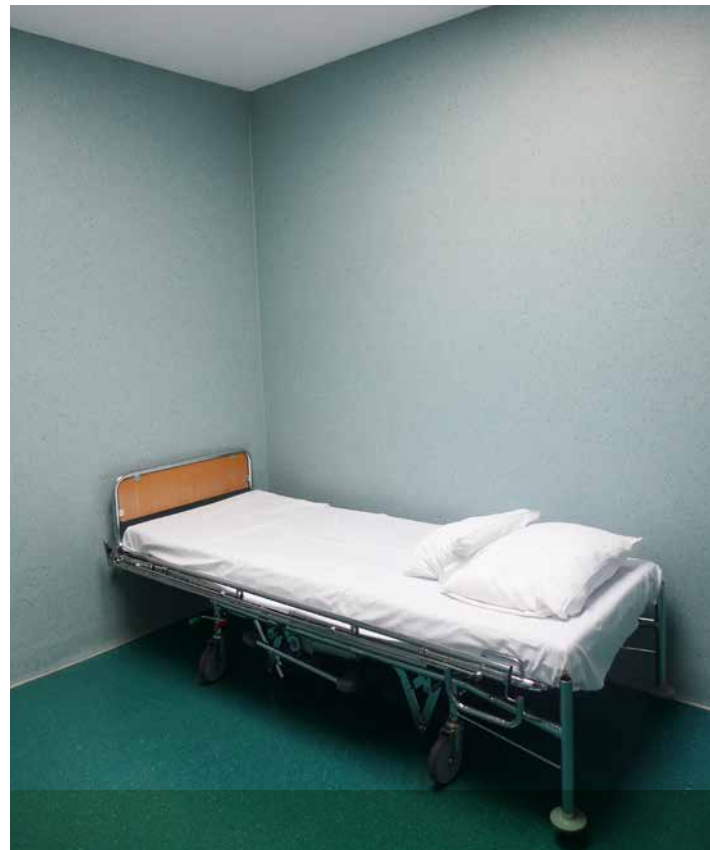
The reports are sent to the place visited and published on the Ombudsman's website. We always request that the report is made available to the people deprived of their liberty and the staff.

The places visited are given a deadline for informing the Ombudsman about their follow-up of the recommendations. Their follow-up is also published on the Ombudsman's website. The Norwegian authorities are obliged to consider the Parliamentary Ombudsman's recommendations and initiate dialogue on possible implementation measures.

Broad approach

The reasons for torture or ill-treatment occurring are complex and influenced by factors such as legal and institutional frameworks, physical conditions, training, resources, management and institutional culture.¹ Effective prevention work therefore requires a broad approach that does not exclusively focus on whether the situation complies with Norwegian law. The NPM's work is largely based on international conventions, guidelines and rules.

The NPM's work also entails information work, dialogue with the public administration, official bodies, supervisory authorities and civil society (see chapter 6). The NPM also cooperates and exchanges information with a number of international human rights bodies (see chapter 7).



A bed at the segregation unit at the psychiatry department at Ålesund Hospital.

¹ See the UN Subcommittee on the Prevention of Torture (SPT), The approach of the Subcommittee on Prevention of Torture to the concept of prevention of torture and other cruel, inhuman or degrading treatment or punishment under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 30 December 2010 CAT/OP/12/6.

The NPM's employees

The NPM has an interdisciplinary composition, and includes employees with degrees in the fields of law, criminology, sociology, psychology, social science and human rights.

It is organised as a separate department under the Parliamentary Ombudsman. It does not consider individual complaints.

If the NPM receives complaints during a visit, they are passed on to the Ombudsman's complaints departments. Members of staff from the complaints departments regularly take part in visits. They provide additional legal expertise, and increasing case officers' knowledge of places of detention also benefits the Parliamentary Ombudsman.



Photo: Mona Ødegård

Employees on 22 January 2018

From the left: adviser Caroline Klæth Eriksen, senior adviser Johannes Flisnes Nilsen, senior adviser Mette Jansen Wannerstedt, ombudsman Aage Thor Falkanger, head of the NPM Helga Fastrup Ervik, senior adviser Jonina Hermannsdottir, senior adviser Christian Ranheim and senior adviser Jannicke Thoverud Godø.

External experts

The NPM has the possibility to call in external expertise for individual visits. External experts are assigned to the NPM's visit team during the preparation for and execution of one or more visits. They can also help to write the visit report and provide professional advice and expertise to the visit team. In 2017, the NPM was assisted by external experts during seven visits.

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External experts are assigned to the NPM's visit team during the preparation for and execution of one or more visits.
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External experts in 2017

PLACE VISITED	EXTERNAL EXPERT
Stavanger University Hospital, Alta Youth Centre and Aleris Alta	Harald Aasen, specialist psychologist, psychology adviser to the Norwegian Board of Health Supervision
Akershus University Hospital, Ålesund Hospital and Åna Prison	Joar Øveraas Halvorsen, psychologist, PhD in clinical adult psychology
Oslo University Hospital, section for psychosis treatment, Gaustad	Gøril Westborg Smiseth, specialist psychologist

New work tool

In 2017, the NPM has started using a new internal work platform. The purpose of the new work platform is to ensure better continuity and flexibility throughout the work process and to be able to share and systematise information more expediently within the organisation.

The work platform is used in connection with every visit, from its announcement, to planning, systematising information, writing reports, and in the subsequent follow-up. The platform also contains a knowledge library. The development and testing of this platform over the course of the year has also enabled the NPM to review a number of work processes.

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Selected topics from 2017

The isolation of inmates with mental disorders in Norwegian prisons

During its visits to prisons in 2017, the National Preventive Mechanism (NPM) has had a particular focus on inmates with mental disorders in isolation in restricted sections. These inmates are particularly vulnerable to inhuman or degrading treatment, and many of them are serving under clearly undignified conditions.

Research shows that a large percentage of inmates in Norwegian prisons have mental disorders. Victoria Cramer of the Regional Centre for Research and Education in Forensic Psychiatry and Psychology in the South-Eastern Norway Regional Health Authority (SIFER-Øst) published a comprehensive study in 2014 entitled 'Forekomst av psykiske lidelser hos domfelte i norske fengsler' (The prevalence of mental disorders among convicted persons in Norwegian prisons).¹ It showed, among other things, that 42 per cent of the participants had some form of anxiety disorder, 12 per cent had one of more risk factors for suicidal thoughts and behaviours, and 4.1 per cent had a current psychotic disorder.

The use of isolation is an invasive coercive measure, and people with mental disorders will be particularly vulnerable to inhuman or degrading treatment when they are completely excluded from company. A number of international guidelines and conventions therefore deal explicitly with the isolation of mentally ill inmates in prison. The UN Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) state, among other things, that:

*'The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures.'*²

During its visits, the NPM often comes into contact with inmates who show signs of mental disorders in the prisons' restricted sections. This includes people who the prisons themselves deem to have serious

1 Cramer, V. (2014). Forekomst av psykiske lidelser hos domfelte i norske fengsler. The Regional Centre for Research and Education in Forensic Psychiatry and Psychology, South-Eastern Norway Regional Health Authority, Oslo University Hospital. The findings in the study led, among other things, to a joint report from the Directorate of Norwegian Correctional Service and the Norwegian Directorate of Health entitled 'Oppfølging av innsatte med psykiske lidelser og/eller rusmiddelproblemer' (Follow-up of inmates with mental disorders and/or substance abuse problems) (2016).

2 The Mandela Rules, Rule 45.

mental disorders, inmates who have been placed in isolation because of acute suicide risk and people with mental disorders who have asked to be excluded from company.

Inmates with serious mental disorders

There are inmates in Norwegian prisons today who have such serious mental disorders that they are unable to function together with other inmates. Some of them are excluded from company for short periods of time, while the NPM has also found during its visits that some inmates have, in practice, been in isolation for months and, in some cases, even years. A common factor for many of them is that the security risk means that a lot of staff resources are required to provide activities for them. They therefore rarely leave their cells and have limited contact with other people. For a number of them, questions can be asked about whether the real reason behind their extended exclusion from company is the deterioration of their mental state resulting from the isolation.

A number of these inmates refuse to have contact with the prison health service and health personnel report finding it difficult to offer health care, despite repeated attempts.

A review of administrative decisions, logs and reports shows that many of the inmates in this category are transferred back and forth between prison and the specialist health service. After a short stay in a mental health care institution, these people often return to isolation in prison without treatment.

Prisons themselves often report that this group of inmates live under what can be described as inhuman conditions, and the Parliamentary Ombudsman has stated that the responsible authorities must implement measures for these inmates to ensure that they receive treatment and are not confined to isolation.

The use of restricted sections or security cells in the event of acute suicide risk

Recent research shows that Norway is high up in the statistics on the number of suicides in prison relative to the population.³ It also shows that the most effective means of preventing suicide is good assessment procedures and human contact through talking to staff and the health service.⁴ Despite this, findings from the NPM's visits indicate that placing people in restricted sections or security cells is common practice when a suicide risk is identified. The reason given by the prisons for this is that they do not have enough staff to be able to monitor the inmates over time in the ordinary prison sections. The staffing level is further reduced at night time and at weekends. In some prisons, this means that health personnel are not available to talk to suicidal inmates. If the risk of suicide is acute, security cells are therefore often the answer.

The NPM has had a particular focus on analysing logs from security cells in instances where inmates have been placed there due to suicide risk. Among other things, the log contains information about monitoring and conversations to break up the isolation. The Directorate of Norwegian Correctional Service's guidelines show that inmates are to be checked every hour, and

3 Suicide in prisons: an international study of prevalence and contributory factors Fazel S., Ramesh T., Hawton K. (2017) *The Lancet Psychiatry*, 4 (12), pp. 946–952. In the article, Norway tops the list for the number of suicides among the countries studied. The source data include the year 2013, when there was an unusually high number of suicides in Norwegian prisons. Norway would still feature high up the list, even if this was adjusted for.

4 Marzano L, Hawton K, Rivlin A, et al. Prevention of suicidal behavior in prisons. *Crisis* 2016; 37: pp. 323–34.

that continuous monitoring should be considered for security cells.⁵ In addition to monitoring by the prison staff, health personnel are obliged to check on the inmates at least once a day. The log entries show that, in most cases, the monitoring consists of a prison officer observing the inmate through a hatch or window to check that the inmate is breathing or showing other signs of life. Even in cases where an inmate is deemed to be at acute risk of committing suicide, the logs show that monitoring entails limited human contact and that conversations of any length are rare.

In most cases, the use of a security cell will mean that it is not possible for the inmate to commit suicide during the acute phase, as the cell contains no objects that can be used for this purpose. However, the NPM's reports have pointed out that the use of security cells can traumatised the inmate. Based on what is known about the effects of isolation, it cannot be ruled out that the use of a security cell as a suicide prevention measure may have the opposite effect, in that the risk of suicide actually increases in both the short and long term. This highlights the importance of exercising particular caution as regards placement in a security cell where there is a risk of suicide or self-harm. If security cells are to be used, however, it is important that there must be more human contact than is the case under the current practice.

Exclusion at own request

A common reason given for exclusion is that the inmate is excluded at his or her own request. A review of administrative decisions and interviews with inmates show that there can be a number of reasons for this. Not feeling safe is often stated as a reason, however. The Cramer study shows that a total of 65 per cent of those included in the study had a primary disorder that could be classified as an anxiety or mood disorder. This includes panic disorders, social anxiety, depressions and post-traumatic stress disorder. Many of the people interviewed by the NPM say that they have chosen to isolate themselves, because of such mental disorders, in their own section or in restricted sections. It would appear that many of those who choose to isolate themselves have an unmet need for treatment, and that inadequate follow-up of this vulnerable group can add to the burden for the inmates concerned.

Based on what is known about the effects of isolation, it cannot be ruled out that the use of a security cell as a suicide prevention measure may have the opposite effect, in that the risk of suicide actually increases in both the short and long term.

5 Guidelines to the Execution of Sentences Act, revised 27 October 2008, statutory and regulatory provisions updated 10 October 2017, section 38.4.

ECT administered on grounds of necessity

In 2017, the National Preventive Mechanism (NPM) has especially examined the practice at mental health care institutions where ECT is administered without the patient's consent. Administering ECT without consent is prohibited, but in some cases, the treatment is given on grounds of necessity. Findings were made during a number of visits in 2017 that highlight that patients are subject to a high risk of inhuman or degrading treatment.

Background

Electroconvulsive therapy (ECT, also known as electroshock therapy) is a form of treatment whereby short, low-voltage electric shocks are administered to the patient's brain. The treatment is administered 2–3 times a week (the total number of ECT treatments is usually between six and twelve), and it is administered under anaesthetic together with a muscle relaxant. Although the treatment is permitted in Norway, experts in the field disagree about the use of ECT and whether it can lead to permanent brain damage.¹ Some patients have experienced serious side effects after ECT (such as memory loss), and a number of them have been awarded compensation from the Norwegian System of Patient Injury Compensation (NPE).²

As ECT is considered to be a serious intervention, it may not be administered without the patient's consent.³ The Norwegian authorities nonetheless allow ECT to be administered without consent on grounds of necessity in special situations.

In the preparatory works to the Mental Health Care Act of 1999, the Ministry stated that the principle of necessity can constitute grounds for administering ECT without the patient's consent, if the patient's life is at risk, or if there is a risk of serious harm to the patient's health.⁴ The Ministry made reference to the provision on the principle of necessity in the General Civil Penal Code (Section 47 of the General Civil Penal Code of 1902). Pursuant to Section 17 of the current General Civil Penal Code, an act that would otherwise constitute a criminal offence is lawful when it is done to save life, health, property or another interest from a danger that cannot be averted in any other reasonable manner, and the danger far exceeds the risk of harm from the action.

1 Aslak Syse, Gyldendal Rettsdata annotated version of the Mental Health Care Act, Section 4-4, last revised on 5 November 2016.

2 See overview: <https://www.npe.no/nn/pasientsikkerhet-og-statistikk/Temaartiklerogfaktaark/Psykisk-helsevern>.

3 The Patient and User Rights Act Section 4-1 and the Mental Health Care Act Section 4-4 second paragraph.

4 Proposition No 11 (1998–1999) to the Odelsting page 108–109.

Criticism on human rights grounds and the health authorities' measures

ECT administered on the basis of the principle of necessity provision in the General Civil Penal Code has incurred criticism from international human rights bodies. In its Concluding Observations to Norway in 2013, the UN Committee on Economic, Social and Cultural Rights advised Norway to stop administering ECT without consent.⁵ Following a country visit to Norway in 2015, the Council of Europe Commissioner for Human Rights questioned whether administering ECT on the basis of the legal principle of necessity was in keeping with human rights standards.⁶ The Commissioner also highlighted the importance of obtaining an accurate overview of the scope of ECT therapy, and making it publicly available.

In a letter to the Ministry of Health and Care Services of June 2016, the Directorate of Health questioned whether the principle of necessity is a sufficient legal basis, pointing out that repeated treatments are required for ECT to be effective.⁷ The directorate recommended that the use of ECT on grounds of necessity be considered further by the committee appointed by the government to conduct an overview of the regulation of coercion in Norwegian legislation (Tvangslovutvalget). The committee will submit its recommendations in September 2018.⁸

The Norwegian Directorate of Health published national guidelines on the use of ECT in June 2017. It was emphasised that it is only relevant to consider administering ECT on grounds of necessity in situations where a patient with a serious mental disorder is in an acute situation, and there is an immediate and serious risk to the patient's life, or a serious risk of harm to their health if they do not receive adequate health care.⁹ According to the directorate, ECT must be seen as the only satisfactory treatment option available to avert acute risk, and no other less invasive treatments are considered to be options, and the intervention must be in accordance with proportionality requirements. The directorate has also set out documentation requirements for each case in which ECT is administered without consent. Patients who believe that ECT was administered unlawfully on grounds of necessity, can submit a complaint to the County Governor pursuant to the Patient and User Rights Act Section 7-2.

In the Ombudsman's opinion, the current application of the principle of necessity as an independent legal basis for intervention/competence base for administering ECT without the consent of the patient is problematic in relation to the Norwegian Constitution's requirement that infringement of the authorities against the individual must be founded on the law.¹⁰ The legal authority requirement is stricter for very invasive measures.¹¹

5 UN Committee on Economic, Social and Cultural Rights, Concluding Observations – Norway, 13 December 2013, E/C.12/NOR/CO/5.

6 Report by Nils Muiznieks, Commissioner for Human Rights of the Council of Europe, following his visit to Norway, 19 to 23 January 2015, CommDH (2015) 9.

7 The Directorate of Health, Concerning use of ECT in grounds of necessity, letter of 4 July 2017 to the Ministry of Health and Care Services.

8 On 17 June 2016, the Government appointed a legislative committee to conduct an overall review of the regulation of coercion in the health and care services sector. The committee is chaired by professor Bjørn Henning Østenstad.

9 The Directorate of Health (June 2017): National guidelines for the use of electroconvulsive therapy (ECT), page 26–28.

10 Article 113 of the Norwegian Constitution.

11 See, inter alia, Norwegian Supreme Court Reports Rt. 1995 p. 530 and Rt. 2001 p. 382.

ECT administered on grounds of necessity entails a high risk of inhuman or degrading treatment

Findings made during the NPM's visits in 2017 have shown that ECT administered on grounds of necessity is a very invasive form of treatment. The Ombudsman has identified cases where mental health professionals have found that patients have suffered serious cognitive side effects following ECT, and where the patients cannot remember having had the treatment. One clear finding was that patients who had undergone ECT on grounds of necessity are also subject to other invasive coercive measures during their treatment, such as the use of a restraint bed for the administration of ECT. The NPM also found cases where the use of force had escalated following a course of ECT on grounds of necessity. The overall scope of the use of force in connection with the administration of ECT on grounds of necessity leads to a high risk of patients being subject to inhuman and degrading treatment.

Problematic aspects of necessity assessments

Problematic findings were made at several of the hospitals visited by the NPM, in relation to the documented assessments of whether grounds of necessity applied. In several cases, ECT had been administered on grounds of necessity although it was unclear whether and why the strict conditions that apply were met. The cases concerned patients with serious conditions, e.g. described as suffering from severe catatonia¹² or experiencing serious side effects of neuroleptics. However, in a number of cases it was not made clear that there was an acute risk to the patient's health that could not be averted by other means. In several cases, it was not documented whether lawful treatment measures had been attempted or considered first. Where ECT had been administered on grounds of necessity because of e.g. the serious side effects of medication or low nutritional intake, there was no explanation of why intravenous fluid and nutrition

administration had not been considered sufficient to avert the risk to the patient's life and health. In one case, an ECT treatment based on grounds of necessity was postponed because the patient had eaten and ECT must be administered on an empty stomach. In another case, the documentation stated that there was a high risk of the patient developing pneumonia, without any explanation of why ECT was considered a suitable measure for averting this risk.

The current practice of administering ECT on grounds of necessity without clear regulation in law also creates a risk of misunderstandings arising with respect to the legislation. The NPM found examples of health professionals who had initiated a course of ECT on the grounds of necessity asking the patient's next of kin for consent to the treatment. Next of kin cannot consent to health care on behalf of a patient, including on grounds of necessity.

The principle of necessity does not confer legal authority for a course of compulsory treatment

In most cases, ECT administered on grounds of necessity was repeated over several days or weeks. One patient underwent 12 ECT treatments over a period of a month. The apparent grounds for this was that there was an ongoing acute risk throughout the period the treatment was administered. The information in the patient record indicated, however, that the patient's condition was not acute during the whole period. In another case, a decision was made to administer a course of ECT therapy on grounds of necessity because the patient had recently interrupted ECT on grounds of necessity after four treatments, which resulted in a deterioration in the patient's health.

¹² Catatonia is a state of motor immobility, in which people maintain rigid and unnatural poses, often for hours at a time. Some of them can seem completely withdrawn and communicate very little or not at all. This condition can lead to insufficient fluid and nutrition intake (Malt, Andreassen, Melle and Årslund, *Lærebok i psykiatri 2012*, Gyldendal Norsk Forlag AS).

Such findings mean that it is important to emphasise that grounds of necessity are never, under any circumstances, a sufficient legal basis for implementing a course of treatment that extends beyond what is strictly necessary to avert an acute risk to a patient's health. The government decided not to adopt legal provisions for administering ECT by force when the Mental Health Care Act was adopted in 1999. The way in which the practice of administering ECT on grounds of necessity has developed can be seen as a circumvention of the legislators' clear intention.

Grounds of necessity or consent?

In many cases, the documentation did not make it clear whether each individual treatment was based on grounds of necessity or not. It was found, among other things, that patients who had initially undergone ECT on grounds of necessity, were subsequently deemed to have given their consent, on the basis that they had not actively refused the treatment. Examples were also found of voluntarily admitted patients undergoing ECT after being subject to a range of other coercive measures, without any documentation of the significance of this for the validity of the original consent.

Findings were also made at a number of hospitals that led to concerns that patients who had formally consented to ECT did not receive sufficient verbal and written information about the treatment, including about the expected effect and possible side effects.

The patient's right to file a complaint

Poor documentation of the decision to initiate ECT on grounds of necessity makes it difficult for patients to exercise their right to complain. It is important that patients are given sufficient verbal and written information about the grounds for and the intervention itself. This is particularly important with respect to this type of intervention, because some patients have difficulty remembering the circumstances surrounding the treatment.

Inadequate overview of the scope

During the NPM's visits this year, it also emerged that local hospitals have inadequate overviews of the scope of ECT administered on grounds of necessity. Prior to the visits, the Ombudsman requested documentation of all the cases, within a specific period, in which ECT was administered on grounds of necessity. Several hospitals had to manually go through patient records and/or resort to health professionals' memory to obtain this information. During one of its visits, it emerged that the actual scope of ECT administered on grounds of necessity was higher than that initially stated. In light of the very invasive nature of ECT, the hospitals should ensure that they have an adequate overview of all cases in which ECT is administered on grounds of necessity.

The hospitals are not obliged to notify national health authorities if ECT is administered on grounds of necessity. There is therefore no national overview of the scope. The Ombudsman has pointed out that it is a cause for concern that the national health authorities are not informed when ECT is administered on grounds of necessity. This means that the health authorities are denied access to important information about a practice with far-reaching effects for the patients who undergo such treatment. An overview of the scope of this practice is a precondition for any critical review thereof. The Ombudsman has raised this issue in its dialogue with the national health authorities, most recently at a meeting with the Ministry of Health and Care Services in October 2017.

Isolation-like segregation in mental health care

A key finding from the visits carried out in 2017 was that a number of mental health care institutions practised extensive segregation of patients. Patients were often segregated in unsuitable premises, with very limited opportunity for human contact and activity. The Ombudsman expressed concern on several occasions that this measure, in practice, resembled isolation.

What is segregation?

Segregation is restriction of patients' freedom of movement and self-determination that exceeds the level otherwise defined for compulsory mental health care. A segregation measure is, in part, considered a treatment measure and, in part, a measure to shield other patients.

Segregation is regulated in Section 4-3 of the Mental Health Care Act, and means that the patient is kept completely or partly segregated from other patients and from personnel who do not take part in the examination, treatment and care of the patient. Segregation can take place in the patient's own room or in a special segregation unit. The responsible mental health professional can decide to segregate a patient for treatment purposes or out of consideration for other patients.

Norway is one of the few countries that uses segregation as a form of treatment, which is in principle distinct from isolation.¹ Isolation is defined in the Mental Health

Care Act as a coercive measure where the patient is detained behind a locked or closed door without a staff member present, while segregation requires close follow-up by the health personnel present.

A systematic review of literature in 2015 concluded that there was little knowledge of the effect of segregation in Norway.² Patient studies indicate that the coercive elements of segregation are stronger than and are perceived as being more isolation-like than treatment purposes would indicate.³

Human rights standards and Norwegian legislative amendments

As segregation entails further restriction of patients' already limited freedom of movement and self-determination, it constitutes an encroachment on patients' right to privacy pursuant to Article 8 of the European Convention on Human Rights (ECHR). Segregation must therefore have a legal basis, and it must be necessary and proportionate in each case. In cases

1 In Denmark, Section 18 d-f of the Psychiatry Act gives institutions the right to practise individual segregation and lock doors in the unit. Announcement No 1160 of 29 September 2015 regarding the act on use of force in psychiatric care (the Psychiatry Act).

2 Norvoll, R., Ruud, T., Hynnekleiv, T. (2015). Skjerming i akuttpsykiatrien ('Segregation in emergency psychiatry'). The Journal of the Norwegian Medical Association, 135, pages 35–39.

3 See note above.

where a person's autonomy is already limited, the European Court of Human Rights (ECtHR) takes a strict view of measures that further limit people's autonomy.⁴ The implementation of segregation measures that provide so little opportunity for human contact that they, in practice, constitute isolation pose a high risk of inhuman and degrading treatment. Human rights standards in mental health care stipulate that isolation cannot be regarded as a therapeutic measure, but only a coercive measure.⁵ Coercive measures must only be used as a last resort and if they are the only way of preventing patients from inflicting harm to themselves or others. The UN Convention on the Rights of Persons with Disabilities has recommended that member states discontinue the use of isolation in legislation and in practice.

The scope of segregation

The use of segregation was extensive in a number of the hospital departments visited by the NPM. Segregation appeared to be an integral part of the treatment regime at some of them, in that a large proportion of the available beds were in segregation units. At one hospital, the number of beds in the segregation units accounted for almost 30 per cent of all beds. Such a high proportion of segregation beds in itself entails a risk that the threshold may be low for using segregation.

It was consistently found that the grounds for administrative decisions on segregation were inadequately documented. The grounds given for segregation being considered necessary were often not sufficiently detailed, and the inadequate grounds also made it difficult for patients to have the administrative decisions reviewed in connection with complaints. The review showed that the administrative decisions often made

reference to agitated behaviour, treatment purposes etc., without this being linked to concrete incidents or circumstances. A number of patients were subject to segregation to prevent them from embarrassing themselves in relation to the other patients, often referred to as 'bringing shame on themselves'. Given that the patients were committed, there often appeared to be a low threshold for acceptable behaviour. Unlawful measures were also identified, such as the routine segregation of substance abuse patients without individual assessments. Other measures, such as the segregation of voluntarily admitted patients in cases where it was not documented that the patient had been informed about their right to discharge themselves, is also problematic. In a number of decisions, no reference was made to whether segregation was implemented as a treatment measure in the interest of the patient or out of consideration for other patients. The findings make it clear that segregation is a difficult mix of use of force and treatment. The fact that there were restraint beds in several of the segregation units visited reinforced the impression of segregation being a coercive measure.

Physical conditions in the segregation units

Segregation measures were often implemented in dedicated segregation units. They consistently had a sterile feel, and the staff and patients at several of the units visited referred to them as being prison-like. The patient rooms were generally painted white with no decoration or pictures on the walls. The rooms had no furnishing apart from a bed and sometimes a table and a chair. It is not clear why all the rooms are furnished with a minimum of furniture and sensory impressions. Recent research does not support the assumption that segregation rooms with a minimum of furnishing reduces mental symptoms or violent

4 *Munjaz v United Kingdom*, Application no. 2913/06, 17 July 2012, section 80: '...when a person's personal autonomy is already restricted, greater scrutiny [will] be given to measures which remove the little personal autonomy that is left.'

5 CPT, 'Means of restraint in psychiatric establishments for adults (Revised CPT Standards)' 21 March 2017, page 2. Also see the recommendation of the Council of Europe's Committee of Ministers, Rec (2004) 10, Article 27 no 1: 'Seclusion and restraints should only be used (...) to prevent imminent harm to the person concerned or others, and in proportion to the risk entailed.' In an international context, 'seclusion' mainly appears to mean that the patient is locked in a room alone.

behaviour. At one of the hospitals, the doorknobs on the inside of the doors to patient rooms were difficult to open, particularly for patients with shaky hands as a result of the side effects of medication or somatic conditions.

In a number of the units visited, the conditions in the segregation unit made it difficult to attend to all the patients' needs, particularly when it was fully occupied. Some of the premises were cramped and inflexible, which made it difficult to be near the patients without appearing invasive. Noise and commotion could lead to increasing unrest and, in some cases, the patients being aggressive towards the staff. Restraint beds in the segregation units increased the risk of patients perceiving segregation as unsafe.

Many of the segregation premises visited did not have direct access to outdoor areas. The patients therefore had to be accompanied out of the segregation units by staff, but this was contingent on staff being available. In practice, many patients were not able to spend time outdoors every day.⁶

Many patients also had limited freedom of movement. A number of the segregation units did not have common rooms. Some of the hospitals had segregation units with access to a communal living room. A high occupancy rate in the segregation units meant that the patients often had to share the time spent in the living room, and were assigned 'living room time'. As a result, the patients had to spend a lot of time in their rooms. At one hospital, beds had been placed in the common rooms in the segregation unit to increase capacity.

Implementation of segregation creates sense of isolation

One key finding was that segregation measures were implemented in ways that meant that the intervention clearly resembled isolation or had to be considered isolation.

At some hospitals, written procedures or informal practices were identified that indicated that blocking a patient's door for a few minutes was regarded as 'part of an administrative segregation decision'. Such coercive measures constitute isolation pursuant to Section 4-8 of the Mental Health Care Act, and can only be implemented in situations where they are absolutely necessary.

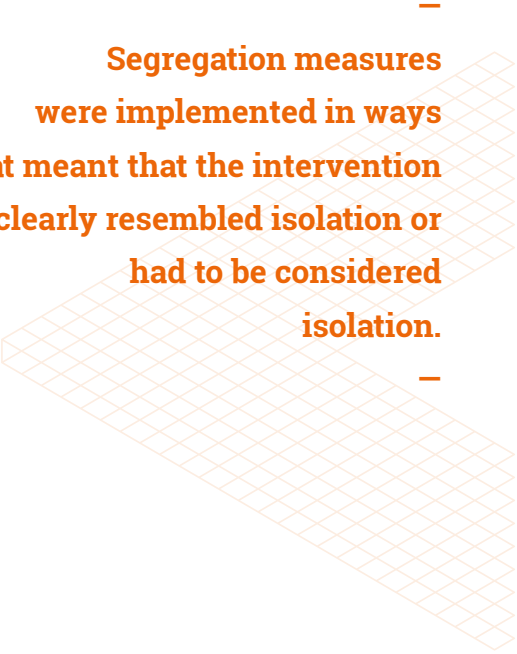
Patients in segregation units spent a lot of their time alone in their room with little contact with the staff. Segregation was often practised by patients being told to stay in their rooms, but without the door being closed. A number of the patients found such verbal messages humiliating, and said that they felt lonely and needed someone to talk to. Where the staff were during segregation varied. A member of staff often sat outside the door of the patient's room, generally with the door slightly ajar or closed. In some places, segregation was practised by the patient being left alone in the unit with the door to the common area left open. The patients were then asked to stay in their own rooms as much as possible, while the staff sat in a spot in the common area, from where they could see into the segregation unit. It appeared to be uncommon for the staff to be together with the patient, although the legislation on segregation requires close follow-up and contact with health personnel.

⁶ By comparison, according to the Mandela Rules, Rule 23 No 1, prisoners shall have at least one hour of exercise in the open air daily. In a number of its reports, the Parliamentary Ombudsman has pointed out that patients in mental health care should also have the opportunity to spend time outdoors every day.

A review of the documentation indicated that segregation was carried out in an unsystematic manner. The hospitals had not set out in writing how they expected segregation to be implemented, such as what kind of treatment and activities the measure was to include. There was no differentiation between segregation for treatment purposes or out of consideration for other patients. At one hospital, the procedures merely consisted of a list of the objects that were not to be found in a segregation room. With few exceptions, segregated patients had little opportunity to engage in activities adapted to their interests and level of functioning. They also had limited access to entertainment such as radio, music and reading materials, and many patients said they were bored. The lack of such entertainment was said to be based on the need to limit sensory impressions, but nor were they made available to other segregated patients. The Ombudsman has pointed out that it is the responsible mental health professional's duty to ensure that segregation measures are not more invasive than strictly necessary.

Findings indicate that many segregation measures are in effect over a long period of time. Pursuant to current legislation, segregation can be maintained for up to two weeks at a time, and for some patients, segregation is extended a number of times. Some patients were subject to segregation over many months. If segregation is maintained over a long period of time without any change in the circumstances that led to segregation being considered necessary, this may indicate that the patient requires a different form of treatment.

Research on isolation in prison has shown that limiting human contact, sensory impressions and self-determination can be harmful to health.⁷ Segregation, particularly if it takes place over a long period of time, poses a risk of inhuman or degrading treatment. Mental health care institutions should therefore give particular consideration to the risk of harmful effects of isolation in their practice.



Segregation measures were implemented in ways that meant that the intervention clearly resembled isolation or had to be considered isolation.

7 For a summary of research findings, see Sharon Shalev, A Sourcebook on Solitary Confinement, LSE/Mannheim Centre for Criminology 2008.



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Visits in 2017

Prisons

Ullersmo Prison, Juvenile Unit East

7–8 February 2017

Ullersmo Prison's Juvenile Unit East is a high security prison with four places for inmates aged between 15 and 19 years. The unit opened on 12 April 2016 and is one of two prisons in Norway for juvenile inmates.

Main findings

The units' basic staff included both prison officers and milieu therapists. The management and employees who form part of the basic staff wear uniforms in their everyday work, except when they participate in leisure activities such as exercise or escort inmates on leave outside the unit. The employees found the use of uniforms unnecessary and an obstacle to developing good relations.

In accordance with a decision by the Norwegian Correctional Service's regional office, the juvenile unit had sometimes had to place juvenile inmates in prisons for adults while waiting for a place at the juvenile unit to become available. This is in violation of the UN Convention on the Rights of the Child, which states in Article 37 (c) that every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so. Juvenile Unit East emphasised that this was a temporary measure. The juvenile unit was responsible for attending to these juveniles while they were temporarily placed in other prisons.

The information booklet handed out to the juvenile inmates on admission was not well suited for the target group – it was formal and inaccessible. There was no written information about the juvenile unit's routines and rules in any language other than Norwegian.

According to documentation submitted by the juvenile unit, use of force was rare. The psychologist worked to prevent violent incidents and use of coercive measures through work with the juveniles and guidance of the staff.

The use of security cells for juvenile offenders is a highly invasive measure that is potentially very harmful. The unit had one security cell. At the time of the visit, the security cell was not approved by the Directorate of the Norwegian Correctional Service, and it had not been used. The security cell appeared much like an ordinary security cell in prisons for adult inmates. This contrasted with the security cell at Bjørgvin Prison's Juvenile Unit, which during the visit to that unit was found to have been designed to minimise the strain on juvenile inmates and give a more humane impression.

Juvenile Unit East had a separate segregation unit. It was stated during the visit that it had been used once for a period of two days. The NPM's review of documents showed that decisions were made and supervision carried out and logged.

At the time of the visit, Juvenile Unit East had not prepared its own procedures for body searches. From a preventive perspective, fixed procedures are important in order to ensure that body searches are conducted in the gentlest possible way. Female staff had been present during body searches of male juveniles on several occasions. The management told the NPM that the use of female staff to search male juveniles would be discontinued.

Juvenile inmates were locked in their cells several times during the day, for example when they were not participating in outdoor exercise or preparing food. It is puzzling that the unit considers it necessary to lock inmates in their cells in this way despite the unit's good staffing level.

According to the unit's weekend routines, juvenile inmates who are locked in their cells both during outdoor exercise and while the food is being prepared will spend six hours outside their cell per day. This is less than recommended by international guidelines,



Ullersmo Prison, Juvenile Unit East

and gives particular cause for concern since these inmates are juveniles.

It emerged that it varied whether the juvenile inmates were given the opportunity for outdoor exercise every day. A contributory cause of this was that the outdoor area was so poorly lit that the prison did not consider outdoor exercise in the afternoon sufficiently secure during the winter months.

There were a total of 3 visiting rooms at the juvenile unit. They were all sparsely furnished and not very welcoming. Juveniles under the age of 18 had the opportunity to call their next of kin and friends for a total of one hour per week. This is half the telephone time that juvenile inmates at Bjørgvin prison are allowed.

Ila Detention and Security Prison

6–9 March 2017

The prison has 124 places divided between 12 sections and 230 employees. More than half of the places are adapted for inmates sentenced to preventive detention.

Main findings

Only two of the sections at Ila Detention and Security Prison had a toilet or shower in the cells. Inmates had limited access to toilets at night. In practice, most inmates therefore chose to urinate in the sink. Several inmates also stated that they had defecated in the rubbish bin. Inmates complained about poor air quality in several sections, and that it was especially cold in Section H in winter.

The inmates largely gave the impression that they felt safe. However, views differed somewhat between inmates in the different sections, and there had been episodes where particular groups of inmates had been harassed. The prison stated that it had a zero-tolerance policy to harassment and bullying, and that immediate action was taken in such cases. Inmates who stated that they did not feel safe mentioned low staffing levels in particular, which led to fewer staff being present in the common areas.

It seems clear that there were persons in Section G with severe mental health problems whose condition had deteriorated during their imprisonment. The prison had made great efforts to have individuals in long-term isolation transferred to mental health care

institutions. The prison administration had itself raised the question of whether what was currently offered in Section G can be classified as inhuman or degrading treatment. The Parliamentary Ombudsman is seriously concerned of the situation in which individuals with mental health problems are subject to long-term isolation. These inmates are entitled to treatment, which the prison is unable to provide within the current framework.

The staff stated that, in general, it was demanding to organise activities that could compensate for the detrimental effects of isolation in Section G. To a certain extent, this is due to the state of the building and, in particular, to the lack of suitable premises for such activities. The Ombudsman observed that the focus on the inmates in long-term isolation meant that other inmates held in isolation risked being offered an activity programme that meant that they had to spend 22 hours or more per day locked in their cells. Research shows that the psychological effects of isolation arise quickly for remand inmates, and that the risk increases with each passing day. For inmates who are held in complete isolation over time, the risk of permanent harmful effects of isolation increases, necessitating measures to counteract such effects.

Upon admission, body searches are carried out in one of the cells in Section G. Otherwise, body searches are conducted in a room beside the front door to the main building. Due to its size and inventory, this room was not suitable for such an invasive act as a full body search. Ila Detention and Security Prison has recently built a new arrival building. The prison administration stated that the physical premises used for body searches will improve significantly once the new building is ready for use.

It was standard practice to have both a male and a female officer present during body searches. The female officer turned her back to the inmate during the last part of the undressing process, but several inmates said that they found the presence of female staff members in the cramped room intrusive. It was also normal for a female officer to be present during the collection of urine samples.

The information the prison provides upon arrival was regarded as good, but several foreign inmates had not received the prisons' information brochure or fire instructions in a language they understood.

The majority of inmates who had been in contact with the health service stated that they received follow-up relatively quickly. The inmates' satisfaction



Photo: Gorm Kallestad / Scanpix

with the follow-up from the health service varied somewhat, but many were highly satisfied. Several inmates found it problematic that, during escorted leave outside the prison, officers were present during consultations and treatment by health personnel.

Ullersmo Prison

29–31 August 2017

Ullersmo Prison is a high-security prison. At the time of the visit, the prison could accommodate around 200 inmates, in 16 sections in 4 units.

Main findings

There were several instances in 2016 and 2017 of Ullersmo Prison not making administrative decisions in connection with the use of security cells pursuant to Section 38 of the Execution of Sentences Act. Errors and shortcomings in the documentation of the supervision of inmates detained in a security cell were also identified during the visit. Logs were kept in different systems, and the systems were not verifiable. Overall, Ullersmo Prison's procedures for the documentation of administrative decisions and supervision in connection with the use of the security cells were deemed very inadequate.

In at least one case, a person who did not understand Norwegian or English was placed in a security cell without access to an interpreter. In one case, an inmate had been detained naked in a security cell for over half a day, and without a blanket or mattress for some of this period. The supervision log did not specify whether the inmate had been offered rip-resistant clothing. Nor did the log specify whether the hatch had been open or there had been any conversation between the staff and this inmate, who was deemed to be suicidal. The Ombudsman is alarmed by this and underlines that a situation like this entails a clear risk of inhuman and degrading treatment.

Inmates who were placed in the restricted section, Z-Øst, were alone in their cells for 23 hours or more a day. The procedure was that inmates were given the opportunity to spend one hour outside in the fresh air per day, which they generally spent alone in the exercise yard. Apart from 1–3 hours a week when the recreational supervisor visited the section, the inmates had no opportunity for activities or human contact. Some of them were never out of their cell for long periods of time. In this section, the inmates were routinely served food through a hatch in the door. This further reduced human contact and reinforced the individual inmate's sense of isolation.

There were regularly inmates at Ullersmo Prison with such severe mental disorders and low level of



Ullersmo Prison

functioning that they were generally unable to be part of the ordinary prison community. They risked spending long periods excluded from the company of others at the Z-Øst section. Information indicated that a low staffing level further limited the follow-up of the isolated inmates. Both the prison staff and the health service confirmed that they were unable to ensure that this group of inmates received treatment.

During the inspection of the Z-Øst section, the NPM visited cells where the standard of hygiene warranted considerable criticism. The inmates who had stayed in the cells did not appear to have received sufficient follow-up and care from either the prison or the health department with respect to cleanliness and hygiene.

The entire Z-Øst section was in poor physical condition, there was limited human contact, few meaningful activities and no measures in place to break up the isolation of the inmates in this section. No one appeared to have designated overall responsibility for those detained in the Z-Øst section over time. Given what is generally known about the harmful effects of isolation, the Ombudsman is very concerned about the level of care for isolated inmates at Ullersmo Prison.

The health department did not have a set procedure for following up isolated inmates or those in a security cell. A number of the inmates did not feel safe in the prison. This concerned a number of sections, and was based on few officers being present in the communal areas in the sections, the exercise yards and in some workplace situations. The physical design of the new section 4 appeared to have a detrimental effect on both the staff and the inmates' sense of security. The exercise yard in section 4, which was completed in summer 2017, was very limited with respect to size and exercise options.

Around 60 per cent of the inmates were said to be employed in the prison. Inmates who had the offer of employment were generally satisfied with this. At several of the sections, those who did not have employment were locked out of their cells for a shorter period than that specified in international standards, for less than five hours on weekdays and less than four hours at weekends in some sections. It emerged that the programme activities had been reduced in recent years.

Åna Prison

13–15 November 2017

Åna Prison is a prison with both high and lower security levels. The prison has only male inmates. During the visit, there were 153 high-security inmates in the prison.

Main findings

The admission of inmates took place in the cellar of Åna Prison, where all the new inmates and their possessions were registered and searched. The admission pamphlet was easy to follow and informative, and it is positive that it is available in a number of languages. However, some of the inmates stated that they had not been given the pamphlet on admission.

It was stated that 75 per cent of the inmates were engaged in work or education. Several of them stated that they were satisfied with the employment they were offered, and most of the inmates who took advantage of educational activities were satisfied with these activities. Many inmates and employees requested more programme activities. The lack of such activities was said to be due to a shortage of resources. Inmates who did not engage in work or educational activities were locked in their cells for the period during which the other inmates were occupied. They spent less time each day outside their cells than the minimum eight hours recommended by the CPT for remand inmates. All of the inmates spent less than five hours outside their cells at weekends.

It emerged during the interviews with inmates that they regarded the exercise options at the prison as poor. Few inmates took advantage of the obstacle course in the exercise yard, and many described it as being too demanding. A number of inmates requested more activity, increased exercise options and better quality exercise equipment. This was particularly the case for inmates in isolation.

The inmates largely gave the impression that they felt safe. However, the inmates in the different sections expressed slightly different opinions in this respect, and more of the inmates in the big communal sections stated that they sometimes did not feel safe. A number of inmates highlighted the exercise yard as an area in which there were instances of physical violence or threats being made.

The security cells at Åna Prison were physically separate from the other sections. The cells' location in the cellar meant that the inmates had to be moved hundreds of metres and down one or more floors. The long distance and narrow stairwell access meant that the staff had, on occasion, used a goods trolley if the inmate was heavy or had put up a lot of resistance. The goods trolley is considered a degrading and unsuitable means of transporting inmates. Both the design and length of the trolley constitute an increased risk of personal injury.

A review of use-of-force records from 1 January 2016 to 20 September 2017 showed that around 35 per cent of all placements in security cells were due to a risk of suicide or self-harm. The staff stated that the threshold for using a security cell in connection with suicide risk was relatively low. This was explained as being due to limited staff resources, and little possibility to increase supervision through a greater staff presence in the communal sections. Both the records and interviews with inmates who had spent time in a security cell showed that many of them had felt abandoned and that they had felt a keen need for more contact with the staff.

The health service was routinely informed about admissions to security cells or the use of restraint beds. Hå accident and emergency unit was notified outside office hours. Inmates confined to restraint beds or security cells were not seen by health personnel outside office hours. This situation could continue for several days at weekends and during holidays. The Ombudsman regards the lack of follow-up by health personnel outside office hours as a matter of grave concern.

Compared with the other prisons the NPM has visited, Åna Prison excludes a very high number of inmates from company pursuant to Section 37 of the Execution of Sentences Act. Åna appears to have a high number of exclusions based on the wishes of the inmates themselves and due to circumstances relating to prison premises and staffing. The Ombudsman is concerned about the apparently high exclusion figures at Åna Prison, and particularly the high prevalence of self-isolation. Both inmates and staff complained about the lack of activities for those fully excluded from company, which was said to be a result of a shortage of staff. It is a cause for concern that a low staffing level means that inmates are isolated in their cells without the prison providing activity and meaningful human contact.



Åna Prison

Mental health care institutions

Stavanger University Hospital's special unit for adults

9–12 January 2017

Stavanger University Hospital's special unit for adults has four sections with a total of 114 beds. Five wards were visited.

Main findings

The wards visited consistently had pleasant and open communal areas. The patient rooms felt bare. Several wards had a strong focus on offering patients opportunities for physical activity, but many would like other forms of meaningful activity, therapy and services adapted to their level of functioning and interests. Most of the wards visited had no direct exit for patients who wanted to spend time outdoors. The patients had limited access to outdoor areas, and the situation was particularly challenging for patients in the segregation units.

The hospital has succeeded in achieving a significant reduction in the use of mechanical restraints, but the use of isolation is prevalent. Important measures had been implemented to prevent the use of coercive measures.

A document review showed that the hospital generally ensures that its use of mechanical restraints is well documented. The documentation showed that many coercive measures were of short duration, with frequent attempts at releasing the patient from the restraints. It nevertheless gives cause for concern that some patients had been continuously restrained in a restraint bed for more than 24 hours. The staff mostly had good practical training aimed at ensuring that patients were restrained in the gentlest way possible. At the same time, some problematic circumstances were identified in connection with the restraining of patients, such as covering of their mouth or face, active involvement by the local police and patients sleeping in restraint beds.

Findings indicate that segregation was an integrated part of the treatment. The physical conditions on the wards, with more than a quarter of patient

rooms located in the segregation sections, seemed in itself to represent a risk of disproportionate use of segregation. The segregation sections had a sterile feel, particularly the patient rooms. Many found the segregation sections prison-like. The premises were cramped and inflexible, which made it difficult to address all the patients' needs, particularly when all the segregation rooms were in use at the same time. Findings made during the visit showed that this was common, and that many patients were therefore told to stay in their room. The doors were not locked, but they were hard to open because of the round doorknobs. This form of segregation gave it a feel of solitary confinement. The measure was perceived as distinctly more invasive than segregation with unrestricted access to the segregation section's living room, since it entailed greater restrictions on the freedom of movement, human contact, activities and stimuli. Most of the wards had also had patients who had been subject to continuous segregation for periods of several months, sometimes for five months or more. Segregation for such prolonged periods of time entails a clear risk of inhuman or degrading treatment, particularly in light of the physical conditions in the segregation sections and the practice of segregation in the patient's own room.

Several patients stated that it was traumatic to take medication against their own will, and some experienced unpleasant side effects of the medication. At the same time, findings indicate that the personnel treating the patients respected the fact that forced medication is a measure that represents a serious violation of a patient's integrity. The document review showed that the hospital mostly ensures good documentation of the assessments carried out before a decision is made. Some decisions were nonetheless inadequate, either in that the person responsible for the decision had not considered whether all the statutory requirements were met, or because the grounds given for the decision appeared inadequate. This applied in particular to the requirement that there must be a 'great likelihood' that the treatment will have a positive effect.

In recent years, Stavanger University Hospital has performed ECT on a small number of patients on the basis of the legal principle of necessity. There is



Photo: Hallgeir Vågnes, VG / NTB Scanpix

Stavanger University Hospital's special unit for adults

particular cause for concern regarding the treatment of one of these patients. The patient came from a minority language background and was subjected to a number of treatments based on the principle of necessity. The documentation suggests that inadequate consideration was given to whether the requirements for treatment on grounds of necessity were met. The findings also indicate that no interpreter was used and no attempt was made to call in an interpreter before an ECT treatment was performed based on the principle of necessity in a situation where the patients could not understand or communicate in Norwegian. Next of kin was asked to consent to the

intervention on the patient's behalf, based on the principle of necessity. ECT on grounds of necessity is a highly invasive and controversial treatment that carries a high risk of inhuman or degrading treatment of patients. The case sheds light on the considerable ethical challenges associated with a practice for which there is no clear basis in health law. It also gives cause for concern that the national health authorities are not notified when ECT is carried out based on the principle of necessity. This means that the health authorities are denied access to important information about a practice with far-reaching effects for the patients who undergo such treatment.

Akershus University Hospital, the emergency psychiatric department

2–4 May 2017

The emergency psychiatric department is part of the hospital's mental health care clinic. The department has 73 beds and six wards were visited.

Main findings

The six wards under the emergency psychiatric department were housed in an older building on the hospital grounds. The wards' communal areas were pleasantly furnished, but the building showed signs of wear and tear and the arrival area did not give newly arrived patients or visitors a positive first impression. A number of patients had limited opportunity to spend time outdoors, particularly patients subject to restrictions on being outdoors and patients in the segregation units. The wards had no direct access to outdoor areas from the communal areas or segregation units.

The department employed two physiotherapists who offered both individually adapted physical activ-

ity and weekly activities for all patients. Other than that, the range of activities available to patients was limited, and there were no alternatives for patients who did not wish or were unable to participate in physical activity.

There were weaknesses in the documentation of the use of force. The concrete grounds for each decision, and particularly decisions regarding treatment without the consent of the patient, were not specific enough and partly based on the wrong conditions. The patient's right to receive the administrative decision was not adequately safeguarded, and the patients were not routinely given the concrete grounds for the decision.

There had been a reduction in the number of times mechanical restraints had been used in the past year. The staff had received training to ensure that patients were restrained in the safest and gentlest way possible. However, conversations with patients who had been placed in restraint beds indicated that many patients did not feel well taken care of while being placed in restraints. It was also worrying that many patients had been strapped to a restraint bed



Akershus University Hospital, the emergency psychiatric department

for longer periods of time, in some cases for more than a day. In some of these cases, it was poorly documented what assessments had been made and what attempts had been made to use less invasive means or release the patient. Several staff members and patients felt that the use of restraints sometimes continued after the situation that necessitated their use had ended.

Findings indicated that patients had sometimes been confined to their room without an administrative decision on isolation being made. It was also found that the threshold for writing administrative decisions on holding of patients was too high, because it was believed that it was unnecessary to write down and record short-term holding of patients even if they objected to the holding.

The segregation units were relatively spacious, and the patients could move around between different rooms within the segregation unit. Segregated patients had limited opportunity to spend time outdoors, including engaging in outdoor physical activities. Furthermore, the practice of regulating the time patients spent in their own rooms and in the segregation unit's living room through daily plans seemed to take little account of the conditions similar to isolation that can arise if the patient is obliged to remain in their own room too much while staying in a segregation unit.

The forced medication figures showed that considerably more administrative decisions had been made in the past year. What arrangements the medical personnel had made to facilitate patient involvement, and what information the patient had received about expected effects and possible side effects, were poorly documented.

In the period from January 2015 to the end of February 2017, the department had performed ECT on eight patients on grounds of necessity. Based on the information provided about the use of ECT on such grounds, several of these treatments seem problematic in relation to the requirements for grounds of necessity.

One ward in particular stood out as having had a poor working environment for a long time, with too few nurses or other staff with relevant professional backgrounds, and a high staff turnover. Several patients in this ward stated that they felt insecure.

Ålesund Hospital, psychiatry department

19–21 September 2017

The psychiatry department at Ålesund Hospital consists of five sections and the Ombudsman visited three of them.

Main findings

The wards visited had pleasant and open communal areas. The activities offered at the hospital psychiatry department were unsatisfactory. Some of the patients in the emergency section were not given the opportunity to spend time outdoors every day. It was difficult to access outdoor areas, which was particularly challenging for patients in one of the emergency section's segregation units.

Several weaknesses were found in the hospital's practice in relation to administrative decisions to use force. Outdated templates were used that increased the risk of the person responsible for the decision not making assessments in line with applicable legislation. Several of the administrative decisions contained poor explanations of why the statutory conditions were found to be met. This particularly concerned segregation decisions and decisions regarding treatment without the consent of the patient. Patients did not receive the grounds for the decision in writing.

Two restraint beds were placed in the waiting room right beside the patient entrance to the emergency section and could make patients already in a vulnerable acute phase feel even more unsafe. Information was provided that gave cause for concern about whether the threshold for using mechanical restraints was too low and indicated that prolonged use of restraints was a challenge in the emergency section. A review showed that patients still often slept in restraint beds, and examples were found of patients not being released from the restraint beds during the night shift due to inadequate staffing.

Information was provided during the visit that indicated that patients were sometimes locked up in their rooms without the person responsible for decisions being informed. Information also emerged that indicated that some cases of short-term holding were not registered as administrative decisions.



Ålesund Hospital, psychiatry department

Many of the patients in the segregation units had little freedom of movement in practice and had to spend a lot of time in their rooms. This was due to a combination of the physical surroundings, capacity challenges and the way in which segregation was carried out.

The segregation units that the NPM visited were sterile and unattractive. Except for a bed, chair and table, the rooms were unfurnished and painted white. The two rooms that were originally common rooms for the patients in the emergency section's segregation units were used by other patients when necessary due to a high occupancy level. One of the segregation units had a separate isolation room. The room appeared to be unsuitable for patients, regardless of the situation.

The implementation of segregation measures seemed unplanned, and many of the patients felt lonely in the segregation unit. Voluntarily admitted patients had been segregated in the emergency section without it being documented that they had been informed about their right to discharge themselves from the institution. A decision on segregation in the emergency section was normally not extended beyond the maximum period prescribed by law of two weeks. However, in the reinforced rehabilitation section, there were instances of some very long-term

decisions being made. For example, one patient had been segregated for more than 3.5 months in the course of a five-month period.

The hospital's practice of using electroconvulsive therapy (ECT) was also reviewed. It was found that the hospital did not have a system for maintaining an overview of the number of ECT treatments administered on grounds of necessity.

A review of four cases where ECT had been administered on grounds of necessity showed that the patients' conditions were deemed to be serious. There seemed to be an awareness of the ethical dilemmas that arise when ECT is administered without informed consent. The review also uncovered weaknesses in the documented assessments of whether the requirements for treatment on grounds of necessity had been met. In several of the cases, treatment with drugs was not relevant because this was seen as having contributed to or even led to the serious condition. It was not clear why other treatment measures were not sufficient to prevent an acute risk to the patient's life or health. In several of the reviewed cases, ECT was administered on grounds of necessity several times. There was little documentation of the assessments made explaining why the requirements for treatment on grounds of necessity were still met.



Oslo University Hospital, psychosis treatment unit, Gaustad

The patients generally described the staff in positive terms such as kind and caring. At the same time, information emerged from both patients and staff members about cases where less invasive means could have been used rather than force. Staff members talked about cases where restraints had been used for longer than strictly necessary and where staff insecurity was a contributing factor. Fear and insecurity among the staff constitutes a clear risk of disproportionate use of force.

Oslo University Hospital, psychosis treatment unit, Gaustad

17–19 October 2017

The unit comprised three inpatient units, two of which were local high-risk psychiatric units and one was a psychosis unit.

Main findings

The high-risk psychiatric units were located in old, run-down premises. The segregation units in the high-risk psychiatric units appeared to be in very poor condition. The segregation unit at the psychosis unit comprised one bare, prison-like room, and no other common rooms. There were separate rooms with restraint beds bolted to the floor in all of the segregation units, and there were several such rooms in each segregation unit at the high-risk psychiatric units.

No errors were found in administrative decisions concerning the use of mechanical restraints or other use of force, as has been the case previously. The written grounds for decisions concerning the use of segregation and being placed in restraints were

not routinely given to patients. New templates for administrative decisions pursuant to the legal amendments made in 2017 appeared, however, to ensure that the grounds were also given to the patients, as the grounds are now included in the decision itself.

The unit had a relatively low prevalence of the use of mechanical restraints, and had focused in recent years on preventing their use. Findings made during the visit indicated that the employees received training and refresher training in ensuring that restraints were used in the safest and gentlest way possible. The mental health professional responsible for administrative decisions performed evaluations with patients after restraints were used. There were also examples of patients sleeping in restraints, and it emerged that mobile restraints had previously been used when patients went outdoors to smoke if they were considered to pose an escape risk.

Many patients had experience of being segregated, and segregation was perceived by the patients as the primary coercive measure in use at the unit. Findings indicated that segregation was often of a short duration, sometimes for just a few hours or 1–2 days in other cases. Segregation appeared to be carried out in a flexible manner, and the staff were aware that it may have harmful effects on or distress the patient. Some of the patients in the ordinary parts of the units could be subject to ‘agreements’ that required them to spend long periods in their rooms during the course of the day. It varied whether a segregation decision had been made when such day plans were used, although the patients felt they had little say in these ‘agreements’. In some cases, the patients were alone in the segregation unit, while the staff sat outside a closed glass door in the ordinary section beside one of the high-risk units.

At the psychosis unit, segregation was primarily carried out in the patients’ own rooms rather than using the segregation unit, as it was regarded as being unsuitable for longer stays. Segregation in patients’ own rooms at the psychosis unit could entail patients spending long periods of time in their rooms, without contact with the staff.

There has been an increase in the number of administrative decisions concerning forced medication at the unit in the past year. The extent to which the

patients felt that they had received sufficient information about the effects and possible side-effects of the medication varied. Administrative decisions concerning forced medication contained very thorough grounds, but the actual conditions on which the intervention was based were not well-enough or specifically described in many of the decisions. New templates for administrative decisions pursuant to the legal amendments in 2017 ensured this was addressed to a greater extent.

Findings made during the visit indicated that visit control was occasionally practised through employees being present in the visit room, without consideration being given to whether the strict conditions for such control pursuant to Section 4-5 of the Mental Health Care Act were met. Some patients also described how they were not allowed visits from various people, again without administrative decisions being made.

Child welfare institutions

Hedmark youth and family centre, unit Vien 4-25

10–11 May 2017

Vien 4-25 is one of three emergency units at Hedmark youth and family centre. The unit admits adolescents aged between 13 and 18 and is approved for the placement of three adolescents under the Norwegian Child Welfare Act Sections 4-25. Vien 4-25 is a closed unit. This means that the doors are locked and leaving the unit is only permitted by agreement with the staff.

Main findings

The unit appeared to limit the use of body searches. In addition, the unit had prepared new procedures for body searches, which implied that the adolescents did not have to be completely naked, but could remove their clothing in two stages. This practice is in line with the CPT’s recommendations.

In some cases, adolescents were excluded from the community rooms and the company of the other young people after admission. In one case



Hedmark youth and family centre, unit Vien 4-25

in 2017, this restriction lasted for three days. The institution did not register administrative decisions limiting freedom of movement in these cases. When the staff decide to deny an adolescent access to the community rooms, this is a restriction on their freedom of movement for which an administrative decision should be made.

The Vien 4-25 unit requested police assistance on several occasions in 2016 and 2017. It is a highly invasive measure to use police assistance inside an institution, and that the institution cannot use the police to carry out its own duties.

Physical force had only been used on a few occasions in 2017, but that force had been used extensively in recent years in relation to some adolescents. Extensive measures appeared to have been implemented by the unit to take care of these adolescents, but the systematic nature of the

situations that resulted in the use of physical force gave cause for concern about whether their health issues could be fully addressed within the framework of a child welfare institution.

It was found during the visit that the unit could strengthen systematic efforts to prevent use of force together with the individual adolescents. It also emerged that the unit did not systematically involve the adolescents in the preparation of plan for their stay (*'plan for akuttoppholdet'*). The management described this plan as the most important document for the individual adolescents' stay.

Vien 4-25 cooperated closely with the local lower secondary school, but stated that it was more challenging to provide a relevant education for adolescents of upper secondary school age if they cannot attend their local school.

The Klokkergården Collective

6–8 June 2017

The Klokkergården Collective is situated in Hedmark and can accommodate 15 persons between the ages of 13 and 18. The institution is approved for placement without the young person's consent. The collective is one of several long-term institutions under the foundation Stiftelsen Klokkergården. The foundation was established in 1980 with the objective to rehabilitate young people with substance abuse and behavioural problems.

Main findings

The Klokkergården Collective made few administrative decisions on the use of force in the past year. However, the institution made many decisions to limit freedom of movement and the use of electronic means of communication in 2016. It seemed that such decisions were made routinely when the young people arrived at the institution.

The institution had a practice of grounding the young people in their rooms if they overslept. This included having to eat their meals in their rooms and they not allowed to participate in social activities.

No administrative decision was made regarding this restriction. This is a clear violation of young people's right to autonomy and privacy and increases the risk of them feeling isolated.

The collective had a practice of taking the young people on what they referred to as 'motivational trips' as part of their treatment. The institution stated that the motivational trip meant that 'a young person leaves the institution together with two adults for a limited period in order to keep an overview of and focus on special tasks.' The institution plan lists four main reasons for organising a motivational trip: reintegration after an escape; special care of a young person after substance abuse; intensifying treatment; and a need for extra care and attention.

However, it was found that violating one of the institution's main rules was also an important reason why the young people were sent on motivational trips. Both staff and the young people stated that one of the reasons for a motivational trip could be if someone had 'secrets' with other young people.

It was found that the motivational trips were mainly carried out following a decision by the staff. 35 motivational trips were organised in 2016, and as of 27 April, 9 such trips had been carried out in 2017. A document review showed that the trips lasted from a few days up to 14 days.



In the Ombudsman's assessment, there was a clear risk that the motivational trips at the Collective were seen as punishment. It was difficult to see any correspondence between many of the circumstances that could lead to a motivational trip and the guidelines to the Rights Regulations concerning 'destructive behaviour' or 'necessary on the basis of the responsibility to provide the individual with care and considerations for everyone's safety and happiness'.

When the staff had decided to take a young person on a motivational trip, they were normally pulled aside by staff members in the hallway near the exit of the main building. If the young person did not wish to go on the trip and did not go out to the car voluntarily, the staff and the young person remained in the hallway until the latter consented to the trip. In such situations, the staff would block the doors in the hallway by standing in front of them to prevent the young person from going anywhere but straight out to the car. The young person was not allowed to return to the rest of the group or to their own room, and nor were they allowed to pack their things.

The young people were not always told about the reason for the motivational trip. Nor were they told how long the motivational trip would last. The management said that the young people couldn't learn about the duration of the trip, because the young person him/herself and the work carried out during the trip determined how long the trip would last. Several of the young people experienced this as the staff waiting for them to 'confess something' and that if they confessed to the rights things, they would be allowed to go back to the institution.

The pressure that was exercised in the hallway before a trip without it being possible for the young person to withdraw to their room, the lack of openness as regards the reason for the trip and its length, the 'phaseless' period and the uncertainty about how long this would last, and the plenary assembly requirement constituted a worrying lack of openness and respect from the institution vis-à-vis the young people.

The fact that, in the past year, there had been an instance where a young person had been subjected to physical pressure to complete a motivational trip, underpins concerns about the risk of inhuman treatment that young people are subjected to through the collective's use of involuntary motivational trips.

Alta Youth Centre

26–29 September 2017

Alta Youth Centre is an emergency institution that accepts young people between the ages of 13 and 18 from Finnmark, Troms and Nordland counties. Alta Youth Centre was approved for placement without the consent of the person in question.

Main findings

The centre very rarely used force in connection with admission. It was emphasised that invasive coercive measures would not contribute to making the young people feel safe while in such a vulnerable phase, and that there are stringent requirements for using force. Alta Youth Centre had generally made few administrative decisions on the use of force in recent years and seemed to be consciously working to avoid the use of force. Among other things, the centre had developed a milieu therapy approach vis-à-vis the young people. The approach is concerned with the young people's individual needs and how the milieu therapy can be adapted and special challenges dealt with for the individual.

Alta Youth Centre very rarely used force that involved restricting the residents' freedom of movement, and that the institution made active endeavours to use other means to make the residents feel safe. Alta Youth Centre found that being followed up too closely could be a trigger for many of the young people, making them retreat more.

A review of protocols and records gave the impression that Alta Youth Centre was thorough in its log keeping and that both logs and use-of-force records provided concrete and individual descriptions. In general, the records contained thorough descriptions of the situations and it was possible for external parties to gain an impression of the staff's experience of and reasoning in the situations. There were also

examples of the young people's assessment of the records being included as separate comments.

Alta Youth Centre had good cooperation agreements in place regarding access to health services and school. The institution had a local cooperation agreement with the Centre for Child and Adolescent Psychiatry in Alta (BUP Alta). The management and staff felt that it had become easier to schedule appointments for the residents at BUP, even if they were only staying in the institution for a short time. Alta municipality also had a cooperation agreement with Finnmark county authority. Through this agreement, the residents at Alta Youth Centre were quickly offered adapted education at lower secondary school.

There had been situations at Alta Youth Centre where residents had been subject to different forms of harassment or bullying by other residents. The institution is responsible for ensuring that residents are not subjected to bullying, exploitation or harassment from other residents. This is an area with great potential risk. The institution had adopted procedures and physical safety measures relating to this problem and maintained a focus on it at meetings and emergency training sessions. The Ombudsman emphasises the importance of Alta Youth Centre continuing to work systematically to prevent harassment and abuse between residents, thereby ensuring that the young people feel safe.



Alta Youth Centre

Aleris Alta

26–29 September 2017

At the time of the visit, Alta had two shared housing units for child welfare in Alta: Mathisdalen and Russeluft. Both of the units are long-term units where young people can spend a prolonged period of time and they were approved for placement of young people between the ages of 13–18 (20) without the consent of the person in question.

Main findings

The institution did not have a procedure for documenting whether the young people arrived there with police, whether coercive measures had been used during the journey or whether coercive measures were in use on their arrival. Information indicated that this had occurred. Using such coercive measures when transporting children and young people is perceived as very invasive. It has a great potential for harm, is humiliating and stigmatising and entails a risk of inhuman and degrading treatment.

Aleris Alta appeared to have good procedures and practices in place for making preparations for the arrival of new young people and looking after them when they arrived at the units. It emerged, for example, that force was rarely used in connection with admission. The employees devoted a lot of resources to preparations for the admission of new young people and emphasised conversation and involvement from the start of their stay.

Aleris Alta had procedures for when and how the police should be notified if a young person runs away, but a separate procedure was not in place for other forms of cooperation with the police. Employees at Aleris Alta expressed their wish for more regular dialogue or an arena for meetings with the police to discuss roles, how the institution and police work and their needs.

Aleris Alta appeared to be restrictive in its use of force such as restrictions on freedom of movement and the use of electronic means of communication. The employees stated that they did not regard restricting young people's freedom of movement

outside the unit to be expedient, and that they tried instead to employ other means of following them up rather than accompanying them outside the house.

The large majority of the administrative decisions to use force at Alta Aleris concerned decisions to collect urine samples, which were carried out with the young people's consent. The employees and management emphasised that collecting urine samples, even with consent, is very invasive. An administrative decision was therefore made in every case to ensure the young people's due process protection and involvement, and to establish a dialogue about their treatment.

Aleris Alta had written procedures for the prevention and handling of abuse. During the visit, all of the staff, however, did not appear to be as familiar with these procedures, and there was uncertainty about how, as employees, they were to proceed if there was a suspicion of abuse.

The employees and management employed a range of different tools and methods to ensure the young people's involvement. Involving them in decisions and plans was highlighted as being the most important means of motivating the young people to complete their treatment and to prevent the use of force. Overall, the visit showed that Aleris Alta takes the young people's opinions seriously and actively consults them and converses with them, which influences their day-to-day life and future.

Immigration detention

The police immigration detention centre at Trandum, the security section

28–29 March 2017

The security section of the detention centre comprised three security cells and eight reinforced cells. During the visit, the Ombudsman examined the detention centre's practice concerning the use of the security section, and the use of coercive measures, such as body-cuffs.



Aleris Alta, Russeluft



Aleris Alta, Mathisdalen

Main findings

The security cells had no furnishings apart from a mattress on the floor. Each cell had a squat toilet. A hatch for passing food through was placed at floor level, about a metre from the toilet. Serving food on the floor can be perceived by the detainees as undignified, and that it is important to serve food and drink in as humane a manner as possible. Objections were also made to the installation of video surveillance systems in the security cells, and it was pointed out that none of the cells in the security section had access to a clock and calendar, making time orientation difficult.

The security section had been used 368 times during the course of 2016. The security cells had been used more frequently at the beginning of 2017 than previously. It was also found that some detainees had been placed in the security section for long periods of time, and in some cases very long periods of time, which raises concerns about their well-being. The detention centre should increase its efforts to limit the time spent in the security section as much as possible.

It is worrying that a large percentage of placements in the security section were based on the detainees' mental health, self-harming or risk of suicide. Placement in the security section normally means that the detainee is placed in isolation and a high risk of harm to health is associated with this. It was pointed out that placing vulnerable persons at risk of self-harm or suicide in the security section as a means of safeguarding them gives cause for concern. Several minors had also been placed in the security section, including in a security cell.

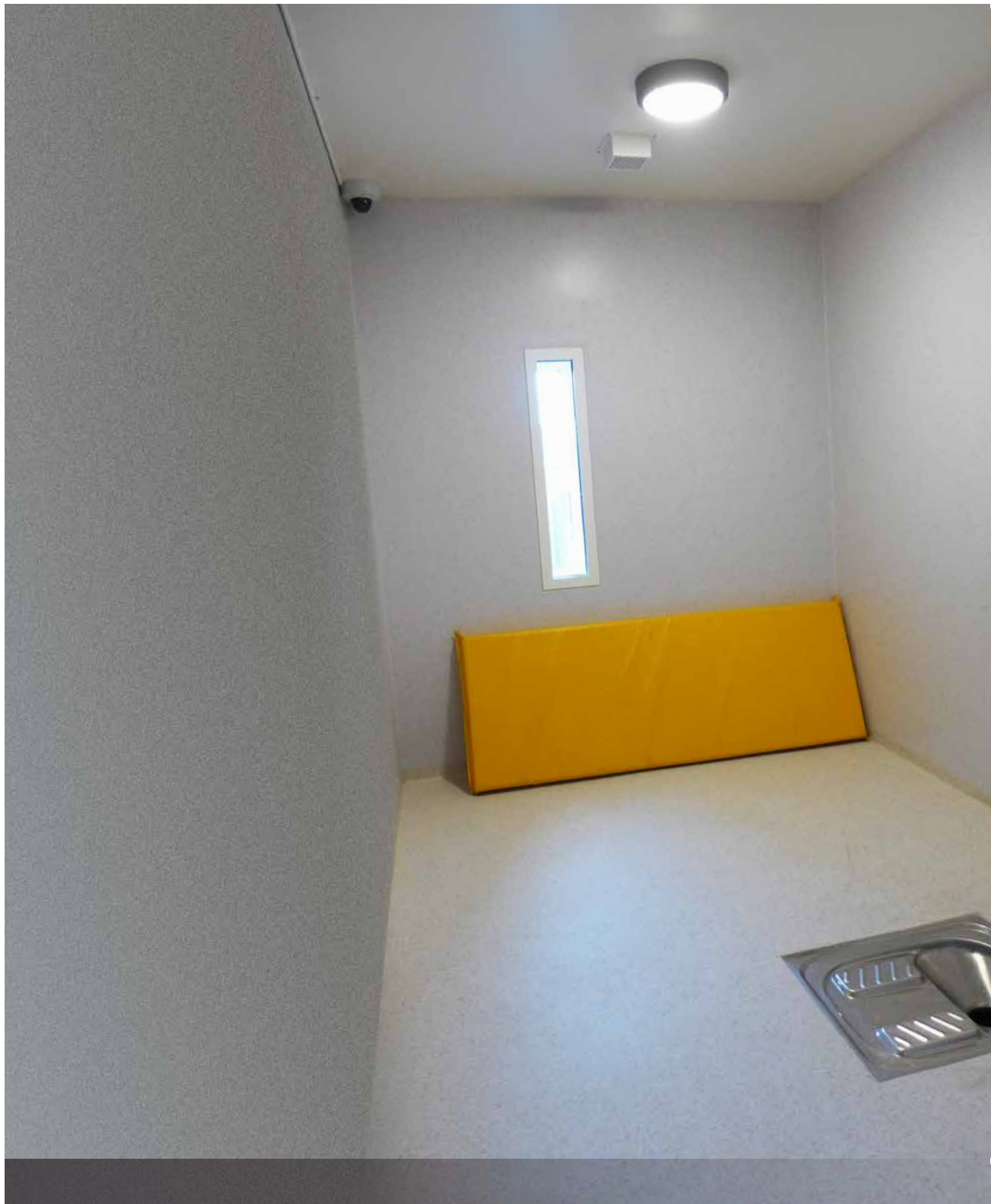
The use of handcuffs in connection with transportation appeared to be a routine procedure and many of those concerned were young people between the ages of 18 and 19. Body cuffs were used in the security section on two occasions. Pepper spray was used on one occasion in a cell in the security section in order to complete a body search. The detainee's eyes were rubbed with the pepper spray from a glove that had been sprayed with the substance. Both the decision to use pepper spray and the way in which force was used appeared questionable in light of the requirements for necessity and proportionality.

The detention centre has implemented measures to prevent the use of force and placements in the security section, such as training and practice in using preventive alternatives. In general, the detainees felt that they were treated in a professional manner. However, authoritarian attitudes among some of the staff appear to have added to the escalation of certain situations. It was concluded that control and security considerations at Trandum are still a major focus, and that there is little leniency in the control regime.

The fact that the medical personnel at Trandum are not sufficiently independent of the Police immigration service remains a challenge, and findings made during the visit substantiated that this contributed to a number of problems. The healthcare service also appears to be of an inadequate scope to be able to safeguard the health of all detainees in a satisfactory manner. The detention centre does not have access to a psychologist.

Findings showed that the medical personnel had advised placing detainees in the security section, and that this advice had, in certain cases, led to the detainees staying there for long periods of time. The fact that medical personnel are directly involved in decisions on placing detainees in the security section is problematic in relation to medical ethics, since the measure can lead to isolation that can potentially harm health.

Problematic findings were also made concerning the medical personnel's duty of confidentiality in relation to one of the doctors at the detention centre. The healthcare department still lacks clear reporting procedures for when physical injuries sustained by the detainees give rise to suspicion of disproportionate use of force.



A security cell at the security section at the police immigration detention centre at Trandum

5



Follow-up of recommendations

After each visit, the Parliamentary Ombudsman publishes a report describing findings and makes recommendations for preventing torture, inhuman and degrading treatment. Feedback is always requested from each place after three months on how the recommendations are being followed up.¹

Feedback received in 2017 shows that the places visited generally appeared to follow up the recommendations in a thorough manner and that they implement measures that are important to reinforcing due process protection and reducing the risk of invasive integrity violations.

The Ombudsman also has regular meetings with central government authorities, where the conditions for people deprived of their liberty are raised .

Some examples of how the Ombudsman's recommendations have been followed up in the past year:

The detention of children at Trandum

Recommendation

- › Following a visit to the police immigration detention centre at Trandum in 2015, it was pointed out that the environment at the immigration detention centre appeared to be characterised by stress and unrest among many of the adult detainees and that such living conditions were not deemed to constitute a satisfactory psychosocial environment for children. The Ombudsman pointed out in his report that the immigration detention centre did not appear to be a suitable place for children.

Follow-up

- › In November 2017, it emerged that children are no longer detained at the immigration detention centre at Trandum. If they are to be deprived of their liberty, it must take place in a more suitable place that is less prison-like and where they are shielded from airport noise. All deprivation of children's liberty, however, entails an increased risk of torture and ill-treatment, and the Ombudsman will closely follow the development of this practice.

Exclusion from company

Recommendation

- › During a visit to Ila Detention and Security Prison, it emerged that the inmates who were not deemed to be in 'long-term isolation' risked being offered an activity programme that meant that they had to spend 22 hours or more per day locked in their cells. The Ombudsman recommended that everyone who was excluded from company and isolated in should have access to satisfactory and meaningful measures to compensate for the detrimental effects of isolation.

Follow-up

- › Following the visit, a working group was appointed at Ila that was specifically tasked with drawing up measures to compensate for the detrimental effects of isolation for inmates who are isolated for short periods. The group mapped which measures had already been implemented to compensate for the detrimental effects of isolation, and presented proposals for further action. The proposals were considered by the management in light of safety and financial considerations, and measures are scheduled to be implemented in 2018.

¹ The follow-up letters and correspondence with the Parliamentary Ombudsman are published on the Ombudsman's website (in Norwegian). See <https://www.sivilombudsmannen.no/besoksrapporter/>.

Police assistance at child welfare institutions

Recommendation

- › During visits to a number of child welfare institutions, the Parliamentary Ombudsman has noted that police assistance is often used in connection with transporting young people, escapes and also inside the institutions, e.g. to carry out body searches. Children and young people are particularly vulnerable during police transport as there is a particularly high risk of force being used. The police also have access to coercive measures, such as handcuffs, which a child welfare institution does not. The Ombudsman has recommended that the child welfare institutions have clear guidelines in place for their cooperation with the police, and that police assistance, including the use of coercive measures, is documented. This is an important means of strengthening young people's due process protection and can help to establish an overview of the scope of the use of police assistance in the child welfare service and in relation to individual children.

Follow-up

- › Akershus youth and family centre, Sole department, has drawn up guidelines for the police's role on the institution's grounds with respect to admission and other assistance, and emphasises that the police's role must always be documented. Hedmark youth and family centre, Vien 4-25 unit, has taken the initiative to speak to the police about the expectations of and delineation between the institution and the police's tasks. The institution has also drawn up a separate procedure for police assistance and made changes to its procedures in connection with admission and return after escapes. The child welfare service's emergency institution for young people in Oslo emphasised after a visit that the police shall not enter the section in instances where they are providing transport, and that the assessments and grounds for other police assistance must be documented.

Information about coercive measures

Recommendation

- › Following its visit to the adolescent psychiatric clinic at Akershus University Hospital, the Ombudsman emphasised that the patient should always receive verbal and written information about the coercive measure and the concrete grounds for the administrative decision (record entry). This is an important means of safeguarding patients' rights and preventing arbitrary use of force. Children and young people are entitled to verbal and written information in the same way as adults.

Follow-up

- › Following the visit, the adolescent psychiatric clinic has made it clear to all its staff who are responsible for administrative decisions that the patients must receive a copy of the decision and a record entry with the grounds for the decision. This was also a topic at the annual in-house course on the Mental Health Care Act, and new members of staff who are responsible for administrative decisions undergo practical training from experienced staff members in this field.

Confidential communication with health personnel

Recommendation

- › Following its visit to Stavanger Prison, the Ombudsman recommended that the prison should ensure that all enquiries to the health department were treated in confidence. Inmates should be informed that request forms for medical consultations can be placed in sealed envelopes, and envelopes should be made available to all inmates. It was also recommended that the line for the prison officer's signature on request forms for medical consultations should be removed immediately.

Follow-up

- › Following the visit, Stavanger Prison and the health department have informed the Ombudsman that they have changed the forms for enquiries to the health department, and that the line for the prison officer's signature has been removed. It has also been introduced as standard procedure that the request forms are to be placed in a sealed envelope by the inmate before being given to a prison officer. This thus enables inmates to be able to contact the health department without having to share confidential health information with others.

Information in a language one understands

Recommendation

- › Most inmates have a great need for information when they are admitted to prison, especially first-time inmates. At a number of the prisons the Ombudsman has visited in the past year, no information has been available for foreign inmates in a language they understand. The Ombudsman has underlined that information for inmates shall be given in a manner and a language that the inmate understands.

Follow-up

- › Kragerø Prison, Juvenile Unit East and Ila Detention and Security Prison have initiated the process of translating information into the most common languages among foreign inmates. Ila was also considering translating a condensed information sheet and the possibility of making an info film in a number of languages. Kragerø Prison stated that the prison has equipment for showing an info film in connection with admission and that an info channel will also be installed on the inmates' TV.

Physical conditions

Recommendation

- › The common rooms, admission rooms and visit rooms at several of the child welfare institutions visited were bare and unpleasant. The Ombudsman has underlined that surroundings are important for children and young people's sense of security and feeling of being looked after. It has been recommended, among other things, that the admission rooms are designed in a way that ensures a dignified admission process in a safe and welcoming environment.

Follow-up

- › Following the visit to the child welfare service's emergency institution for young people in Oslo, the institution has refurbished one of the admission rooms, put in a sofa and table and bought posters for the walls, so that it now looks more welcoming. Akershus youth and family centre, Sole department, purchased furniture, rugs, plants and pictures to make the common areas more pleasant. The visit room has also been painted and three resident rooms have been redecorated.

Due process protection relating to use of a chair in connection with forced nutrition

Recommendation

- › The adolescent psychiatric clinic at Akershus University Hospital had a separate room with four chairs attached to the floor for use in connection with forced nutrition. The room also contained a padded restraint for the patient's chair in the middle, which was sometimes used. The padded restraint was secured across the patient's thighs to make it more difficult for him or her to use his/her legs to resist. After the visit, the Ombudsman raised the question of whether the chair, in cases where this padded restraint was used, is to be considered a coercive measure that is not covered by an administrative decision for short-term holding. It was recommended that this should be looked into.

Follow-up

- › Following the visit, the hospital has stated that it has considered whether the chair used for tube-feeding is a coercive measure. It was decided that, when used with a padded restraint, the chair is to be regarded as a coercive measure and that an administrative decision must be made on the use of a mechanical restraint, cf. Section 4-8 of the Mental Health Care Act and Section 24-26 of the Mental Health Care Regulations. Information about this has been given to all the staff at the section.

Suicide prevention

Recommendation

- › It emerged during visits to Ila Detention and Security Prison and Stavanger Prison that many inmates were unsure of whether they had been asked about suicide risk and mental health just after their admission. The Parliamentary Ombudsman therefore recommended that the health services should ensure that suicide risk is always assessed during the initial admission interview.

Follow-up

- › The health services at Ila Detention and Security Prison and Stavanger Prison have stated that the procedures for mapping and dealing with suicide risk have been changed so that all new inmates are asked about their mental health and whether they have suicidal thoughts on admission. At Stavanger Prison, a 24-hour visitor project has also been initiated for new prison inmates in cooperation with the Norwegian Red Cross. This also applies to remand inmates subject to court-imposed restrictions. The project entails that all remand inmates can immediately receive a visitor from the visitor service, and a phone line has been established at the Red Cross for this purpose.

Activities and outdoor areas

Recommendation

- › Most of the wards the Ombudsman visited at Stavanger University Hospital's special unit for adults had no direct exit for patients who wanted to spend time outdoors. The patients had limited access to outdoor areas, and the situation was particularly challenging for patients in the segregation units. Following the visit, the Ombudsman recommended that all patients should have the opportunity to spend at least one hour outdoors every day. It was also recommended that the hospital, in consultation with the patients, should ensure a varied range of activities adapted to the individual patient's level of functioning and interests.

Follow-up

- › The hospital has informed the Ombudsman that one hour of outdoor activity will now be a point adopted in all patients' treatment plans. Since the Parliamentary Ombudsman's visit, a new garden, called 'Sansehagen' (the sensory garden), has been built on the hospital grounds. The garden is shielded from public view and can be used by all patients in the section, whether they can go out on their own or need to be accompanied by staff. The hospital also planned an inspiration day for the staff, to focus on physical activity as part of treatment, that exercise is good for health and with good examples from their own clinics.

Segregation on arrival**Recommendation**

- › During the visit to Hedmark youth and family centre, Vien 4-25 unit, it emerged that the unit had an admission procedure where, in some cases, young people spent the initial period after admission in an admission room, away from the other young people in the unit. No administrative decisions were made regarding limiting freedom of movement when admission was carried out in this manner. It was underlined that the institution cannot routinely limit young people's freedom of movement on admission and that a concrete assessment must be made in each case. The Ombudsman also underlined that the young people's' due process protection should be safeguarded by making administrative decisions in cases where young people are excluded from the company of the other young people.

Follow-up

- › The Vien 4-25 unit stated that, following the Ombudsman's visit, the young people who come to the institution are now carefully assessed and consideration is also given to whether there are grounds for limiting their freedom of movement in and outside the institution's grounds in each concrete case. In cases where this is considered necessary given the purpose of the stay, administrative decisions are always made and the young person's right to complain is upheld.

Stays in security cells**Recommendation**

- › Following the visit to Stavanger Prison, the Ombudsman recommended that the security cells be equipped with necessary equipment such as a safety blanket and clock, and that action be taken to enable the light to be dimmed at night. Suicide prevention clothing should only be used as a last resort following a concrete suicide risk assessment. Inmates in security cells should be offered the opportunity to spend time outdoors, particularly if held there for more than 24 hours.

Follow-up

- › Stavanger Prison has informed the Ombudsman that the dimmer switch was improved during the Ombudsman's visit, and that suicide prevention clothing has been ordered. The prison has also changed its procedure so that inmates are given the opportunity to spend time outdoors during a stay in a security cell.

6x



National dialogue

External work has been an important element of the NPM's prevention work throughout 2017. National dialogue is an important means of spreading information about the NPM's mandate and its findings and recommendations from visits, and of increasing its support among the places it visits and the public administration. The advisory committee has also regularly contributed input to this work, and the NPM has held meetings with civil society, given talks at different events and continued its dialogue with the authorities.

The advisory committee

The advisory committee contributes information, knowledge and input to the prevention work. The committee is diverse and comprises 15 organisations with relevant expertise.

The members of the advisory committee at a committee meeting in 2017.



In 2017, the committee comprised representatives of the following organisations:

- › The Norwegian National Human Rights Institution
- › The Equality and Anti-Discrimination Ombudsman
- › The Ombudsman for Children
- › The Norwegian Bar Association's Human Rights Committee
- › The Norwegian Medical Association, represented by the Norwegian Psychiatric Association
- › The Norwegian Psychological Association's Human Rights Committee
- › The Norwegian Organisation for Asylum Seekers (NOAS)
- › The Norwegian Association for Persons with Intellectual Disabilities (NFU)
- › Jussbuss
- › The Norwegian Association of Youth Mental Health
- › We Shall Overcome
- › The Norwegian Research Network on Coercion in Mental Health Care (TvangsForsk)
- › The Norwegian Helsinki Committee
- › The Retretten Foundation
- › Amnesty International Norway

The advisory committee held four meetings in 2017. The topics of the meetings included work methods, use of force in transition situations, the role of health personnel in treating people deprived of their liberty, and detention of children in connection with deportation. The committee members also provided input to the prevention work in between the meetings.

Four meetings of the advisory committee are planned in 2018.

The Parliamentary Ombudsman is also represented on the advisory committee to the Norwegian National Human Rights Institution, which regularly discusses topics of general interest to the Ombudsman and of special interest to its prevention work. It is also in constant contact with the Ombudsman for Children and the Equality and Anti-Discrimination Ombudsman.

The annual human rights seminar

On 26 October 2017, the Parliamentary Ombudsman held its annual human rights seminar in Oslo. The topic of the seminar was: 'The role of health personnel in relation to people deprived of their liberty in police custody facilities and prisons'.

Around 200 people from the Correctional Service, the health sector, the police and other relevant parts of the public administration attended, as well as experts in the field and voluntary organisations.

The seminar was opened by experts from Norway and abroad. Two panel discussions featuring representatives of different bodies and professions discussed the challenges police custody poses for the police and accident and emergency departments, and the relationship between the Correctional Service and prison health services, respectively. Representatives of the Norwegian Police Directorate, the Directorate of Norwegian Correctional Service and the Directorate of Health were invited to a final panel discussion to brief the audience about what the central public administration does to ensure good health services for people deprived of their liberty in police custody facilities and prisons, and how the authorities can, by contributing to the cooperation between the police, the Correctional Service and prisons, ensure the protection of these people.

Videos of the presentations and panel discussions are available at the Parliamentary Ombudsman's website.¹

¹ See <https://www.sivilombudsmannen.no/aktuelt/menneskerettighetsseminar-26-oktober-2017/>.

The Parliamentary Ombudsman's human rights seminar 2017.



Lectures and talks

The Ombudsman and the NPM staff have given a number of talks at conferences and seminars during the year.

Talks were given at the following events, among others:

- › National forum for emergency psychiatry
- › Network meeting of the emergency psychiatry network *Akuttnettverket*
- › Annual national criminal law conference in Loen
- › One-day meeting on the topic use of force, Vestfold Hospital and Telemark Hospital
- › Conference on women under the responsibility of the Correctional Service

- › Seminar on due process protection for patients in mental health care
- › Meeting of the heads of supervisory councils under the Correctional Service
- › Supervisory Commission Conference 2017
- › Talk at the Equality and Anti-Discrimination Ombudsman's seminar on the use of force in relation to people with disabilities.

The NPM has also taught doctors in specialist training at Oslo University Hospital, the R&D department at Akershus University Hospital (Ahus) and at a seminar on the police custody system organised by the National Police Directorate. The NPM has also held meetings with civil society. See the list of the NPM's activities on page 70.

Helga Fastrup Ervik and Jannicke Thoverud Godø during a lecture for doctors in specialist training at Oslo University Hospital.



Dialogue with the authorities

In 2017, the Parliamentary Ombudsman has had meetings with the Ministry of Health and Care Services and the Ministry of Justice and Public Security where a number of its findings and recommendations from its prevention work were discussed. The Ombudsman also attended the Directorate of Norwegian Correctional Service's conference for heads of units on 4 December, where he gave a talk on complaint cases and the Ombudsman's preventive work in the Correctional Service's area of responsibility.

The follow-up work after the publication of reports is another important part of our dialogue with the authorities. This mainly involves the places visited, but some issues are also raised with the responsible directorates and ministries. Read more about the follow-up of recommendations from visits on page 51.

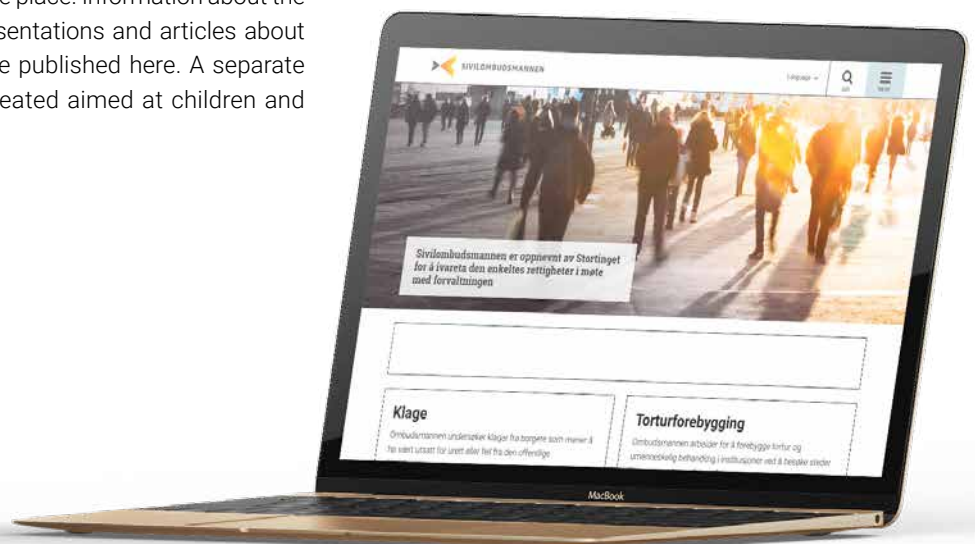
Information work

In May 2017, the Parliamentary Ombudsman launched its new website. Statements on complaint cases and reports from visits are the main focus of the new website, as they constitute the core of the Parliamentary Ombudsman's work. A separate page on the torture prevention mandate has been retained in the new website, so that all the information relating to this work can be found in one place. Information about the visits, visit reports, presentations and articles about the NPM's activities are published here. A separate page has also been created aimed at children and young people.

Some of the Ombudsman's communication materials have been revised and updated and given a design in line with the Ombudsman's new graphic profile from 2016. A new brochure has been prepared about the Ombudsman's functions, and a new brochure and poster on the preventive work have been prepared for use in connection with visits.

In autumn 2017, the Parliamentary Ombudsman started using an electronic newsletter to share information about reports, statements and other matters. A number of the reports from the preventive visits have been sent as newsletters to a growing number of subscribers.

The Ombudsman has also commented on a number of the reports from the preventive visits in the media.





International cooperation

In 2017, the National Preventive Mechanism (NPM) cooperated with other countries' preventive mechanisms and exchanged information and experiences with a number of international parties. The NPM attended conferences, meetings and seminars, and received visiting delegations that wanted to learn more about the torture prevention work in Norway.

UN Committee recommends follow-up of the thematic report on prison conditions for women in Norway

On 7 November 2017, the UN Committee on the Elimination of All Forms of Discrimination against Women examined Norway's follow-up of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). In that connection, several parties submitted alternative reports to the UN Committee on the situation for women in Norway. On 23 January 2017, the Parliamentary Ombudsman submitted its 2016 thematic report on women in prison. At its meeting with the Committee prior to the examination of Norway, the Norwegian National Human Rights Institution (NIM) also placed particular emphasis on the Parliamentary Ombudsman's thematic report.

Several of the recommendations in the thematic report were followed up in CEDAW's Concluding Observations for Norway of 17 November 2017. The Committee pointed to several conditions described in the thematic report, and expressed concern about the poor physical conditions in prisons where female inmates serve, the fact that women are at greater risk of serving their sentences in prisons with poor access to appropriate outdoor areas, and that the health services are not adapted to women, including mental health services and substance abuse rehabilitation services.

The Committee went on to recommend that Norway step up its efforts to improve the prison conditions for women so that they are equal to that of male inmates, and to improve the health services for female inmates. The Norwegian authorities now have two years to follow up the recommendations.

Kirsten Sandberg gave a presentation about assessments of the best interest of the child during the Nordic NPM network meeting in Oslo.



The Parliamentary Ombudsman's thematic report on women in prison has also been sent to the UN Subcommittee for the Prevention of Torture (SPT), and distributed through the global Ombudsman network and other newsletters.

Nordic network of national preventive mechanisms

Two meetings of the Nordic network of national preventive mechanisms were held during 2017. The first took place in Helsinki in January, and the topic of the meeting was methods, with emphasis on interview techniques. The first day was set aside for sharing experience and discussion between the Nordic countries. A course on interview techniques was held on day two, focusing on interviews with patients in mental health care.

NPM staff from Sweden, Denmark, Finland, Iceland and Norway were gathered in Oslo in August 2017 to discuss the conditions for children who are deprived of liberty.



The second network meeting was held in Oslo, and its topic was children deprived of their liberty. Kirsten Sandberg, professor at the University of Oslo and a member of the UN Committee on the Rights of the Child, gave a talk on considerations when determining the best interests of the child and prevention work. The Danish Ombudsman's children's office (Børnekontoret) shared its experience of visiting institutions where children and young people are deprived of their liberty. There was also time to discuss the use of coercive measures and police assistance when transferring young people between different institutions and places where they are deprived of their liberty.

Summer school on the Mandela Rules

In August 2017, the organisations Association for Prevention of Torture, Penal Reform International and the Human Rights Implementation Centre of the University of Bristol, organised a summer school for national preventive mechanisms and other organisations working in the field of torture prevention. The topic of the summer school was 'Torture prevention through

the application of the UN's Mandela Rules', and it was organised as a series of interactive modules that each dealt with a specific area of the updated UN Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) from 2015. The participants learned more about the rules for invasive coercive measures, isolation, documentation, consideration of complaints and supervision, body searches, the health services and the role of health personnel.

Group work outside during the summer school on the Mandela Rules.



Representatives from 17 different organisations attended the summer school, including two employees from the NPM. Head of the NPM Helga Fastrup Ervik was one of the speakers at the summer school.

Seminars and conferences

The NPM's staff have also attended seminars and conferences abroad in 2017, including a conference on the use of isolation as a form of disciplinary punishment, organised by the Danish Institute Against Torture (Dignity). Helga Fastrup Ervik attended a seminar in Dublin marking the tenth anniversary of Ireland signing the OPCAT, and gave a talk on the experience gained from establishing the NPM in Norway.

International visits to the Ombudsman

The Ombudsman received visiting delegations from Tajikistan, Nepal, Russia and Estonia, among others, in 2017. They wished to learn about how the NPM is organised in Norway and the work methods it employs.

On 25 October, the day before the Parliamentary Ombudsman's annual human rights seminar, a meeting was held at the Ombudsman's office with international expert Dr Jörg Pont on the role of health personnel in relation to people deprived of their liberty. Representatives of the Ombudsmen in Iceland and Sweden also attended the meeting.

European cooperation

In 2017, the NPM has regularly provided input to the European newsletter for national preventive mechanisms, which is published by the Council of Europe.

The NPM also attended a conference organised by the Council of Europe in Strasbourg in April 2017, where establishing a network of national preventive mechanisms in Europe was discussed. In addition to discussing this initiative, the participants shared their experience of reporting, recommendations and follow-up of relevant parties.

On 30 May 2017, a number of Europe's national preventive mechanisms sent a joint letter to the EU, the OSCE and the Council of Europe. In the letter, they emphasised the importance of the national preventive mechanisms playing a leading role in determining how they are organised in networks, share information and cooperate. They expressed concern that meetings and projects were being planned for the implementation of OPCAT, without the national preventive mechanisms being consulted or actively involved. It was also emphasised that support from international organisations in connection with prevention work would be more effective if it was given through networks led by the national preventive mechanisms themselves.

Parliamentary Ombudsman Aage Thor Falkanger was one of the Ombudsmen who signed the letter, together with the ombudsmen of Denmark, Sweden, Georgia, Malta, Hungary, France, the UK and Poland, among others.

Reports in English

In order to be able to share experience and information with international parties in the prevention field, summaries and recommendations from the Parliamentary Ombudsman's visit reports are translated into English and published on the Ombudsman's English website.¹



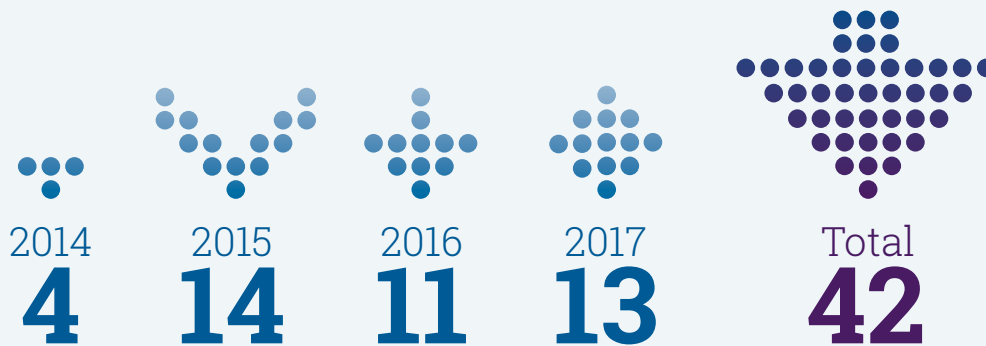
¹ See: <https://www.sivilombudsmannen.no/en/visit-reports/>.

Statistics

Number of visits in 2017, per sector

SECTOR	NUMBER
Prisons	4
Mental health care institutions	4
Child welfare institutions	4
Immigration detention centre	1
Total	13

Number of places visited since start-up, per year:



Visits in 2017

	DATE OF VISIT	PLACE	SECTOR	DATE OF PUBLICATION OF VISIT REPORT	PARTICIPATION OF EXTERNAL EXPERT
1	9–12 January	Stavanger University Hospital, special unit for adults	Mental health care	8 May 2017	Yes
2	7–8 February	Ullersmo Prison's Juvenile Unit East	Prison	20 June 2017	No
3	6–9 March	Ila Detention and Security Prison	Prison	21 August 2017	No
4	28–29 March	The police immigration detention centre at Trandum	Immigration detention centre	15 September 2017	No
5	2–4 May	Akershus University Hospital, emergency psychiatry department	Mental health care	23 October 2017	Yes
6	10–11 May	Hedmark youth and family centre, Vien 4-25 unit	Child welfare	5 September 2017	No
7	6–8 June	The Klokkergården Collective	Child welfare	9 November 2017	No
8	29–31 August	Ullersmo Prison	Prison	14 February 2018	No
9	19–21 September	Ålesund Hospital, hospital psychiatry department	Mental health care	13 December 2017	Yes
10	26–29 September	Alta Youth Centre	Child welfare	29 November 2017	Yes
11	26–29 September	Aleris Alta	Child welfare	16 February 2018	Yes
12	17–19 October	Oslo University Hospital, psychosis treatment unit, Gaustad	Mental health care	1 March 2018	Yes
13	13–15 November	Åna Prison	Prison	15 March 2018	Yes

Consultation submissions

The Parliamentary Ombudsman made a number of consultation submissions in 2017, one of which was particularly relevant to the prevention mandate:

31 May 2017

Consultation submission to Official Norwegian Report NOU 2016:24 New Criminal Procedure Act

All of the consultation submissions are available on the Parliamentary Ombudsman's website.¹

National dialogue



36
External
meetings



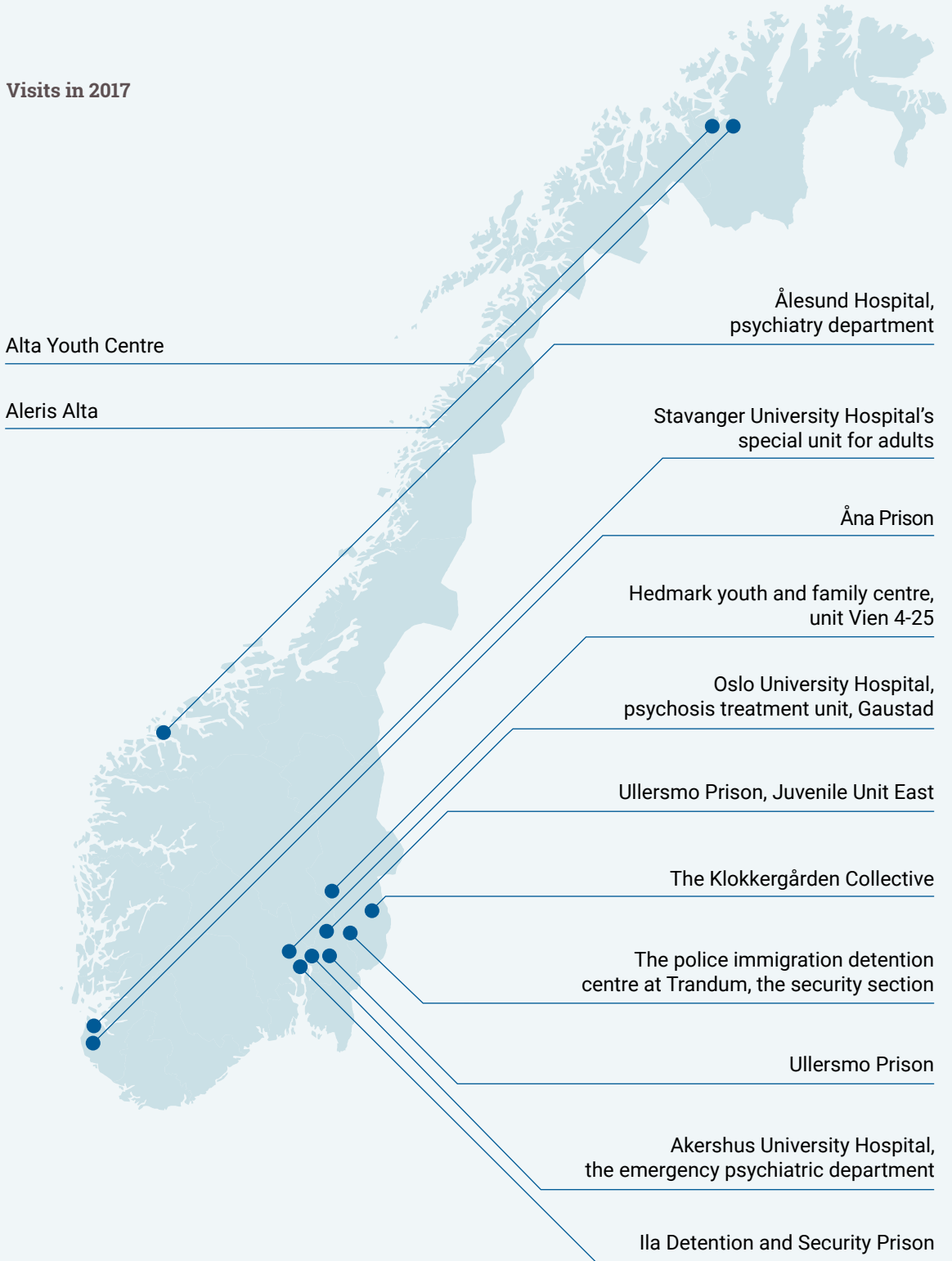
34
Participation
at conferences
and seminars



22
Lectures

¹ <https://www.sivilombudsmannen.no/publikasjoner/horingsuttalelser/>.

Visits in 2017



Activities in 2017

WHEN	ACTIVITY
4 January	Meeting with Chief Parliamentary Ombudsman Elisabeth Rynning and head of the NPM in Sweden Gunilla Bergerèn
10 January	Breakfast meeting to launch the Equality and Anti-Discrimination Ombudsman's alternative report to the UN Committee on the Elimination of All Forms of Discrimination against Women
14–15 January	KROM (Norwegian Association for Penal Reform) conference 2017
17–18 January	Meeting of Nordic national preventive mechanisms in Helsinki
18 January	Visit to Jusshuset/Gatejuristen
18 January	Meeting of the advisory committee to the Norwegian National Human Rights Institution (NIM)
26 January	Meeting with the management of the Correctional Service Region East
31 January	Meeting on consultation on proposals for amendments to the provisions on coercive measures in the Immigration Act
2 February	Talk at the national forum for emergency psychiatry
13 February	Meeting of the advisory committee to the National Preventive Mechanism
15 February	Launch of UNICEF's report on the sustainable development goals and children in Norway – a status report
16 February	Working lunch with the Norwegian National Human Rights Institution
16 February	Visit by a delegation from Tajikistan
28 February	Webinar: How to Get Involved in the UN Global Study on Children Deprived of Liberty
2 March	The prison radio service Røverradioen's event on prison inmates with mental health problems
6 March	Launch of the book 'Menneskerettighetene og Norge'
16 March	Lecture for international law students at the University of Oslo
17 March	Meeting with the Norwegian Board of Health Supervision
28 March	Launch of the Norwegian National Human Rights Institution's annual report for 2016
30 March	The Parliamentary Ombudsman submitted the annual reports for 2016 to the Storting's Presidium repr. by Marit Nybakk
30 March	Presentation of the annual reports to the Storting's Standing Committee on Scrutiny and Constitutional Affairs

WHEN	ACTIVITY
3 April	Attended a conference on the use of isolation as a form of disciplinary punishment, organised by the Danish Institute Against Torture (Dignity)
3–4 April	Attended the 30th anniversary of the Norwegian Centre for Human Rights
4 April	Lecture at the network meeting of the emergency psychiatry network Akuttnettverket
4–5 April	Meeting organised by the Council of Europe on European cooperation between national preventive mechanisms
5 April	Jussbuss launched a new podcast at a breakfast meeting on Norgerhaven Prison, where the Ombudsman took part in the panel discussion
6 April	Breakfast seminar to launch the Parliamentary Ombudsman's 2016 annual reports Topic: The Convention on the Rights of the Child's requirements of the public administration's case processing and the results of the torture prevention work
19 April	Meeting with the Ministry of Justice and Public Security
24–25 April	Talk at the annual national criminal law conference in Loen, under the topic 'Prison, what it is and what it should be'
8 May	Meeting of the advisory committee to the National Preventive Mechanism
9 May	Talk at the one-day meeting on the topic use of force, Vestfold Hospital Trust and Telemark Hospital
11 May	Launch of researcher Thomas Horn's book at the seminar 'Isolation – proposal for a new Criminal Procedure Act, human rights and legal politics'
16 May	Breakfast meeting: 'Vulnerable inmates – report on prison conditions for vulnerable groups in prison', organised by the Equality and Anti-Discrimination Ombudsman
23 May	Launch of NOAS' report on the deportation of children
29–30 May	Attended a conference on how to deal with violence and threats in the health and social care sector
29–30 May	Attended the Child Welfare Conference 2017
1 June	Meeting of the advisory committee to the Norwegian National Human Rights Institution (NIM)
1 June	Meeting with associate professor Merete Havre of Oslo and Akershus University College of Applied Sciences on due process protection at child welfare institutions
8 June	Cooperation meeting with the Norwegian National Human Rights Institution, the Ombudsman for Children and the Equality and Anti-Discrimination Ombudsman
14 June	Meeting with researcher Yngve Hammerlin of the Correctional Service of Norway Staff Academy (KRUS) on suicide prevention in prison
19–20 June	Conference of European Ombudsmen in Brussels

WHEN	ACTIVITY
14–17 August	Summer school in Bristol on the Mandela Rules
22 August	Lecture by and internal meeting with Marius Storvik, researcher at the University of Tromsø
23–24 August	Meeting of Nordic preventive mechanisms in Oslo
28 August	Meeting with Russian lawyers working in the field of human rights
30 August	Cooperation meeting with the Norwegian National Human Rights Institution, the Ombudsman for Children and the Equality and Anti-Discrimination Ombudsman
1 September	Summer seminar at the psychiatric clinic at Lovisenberg Diaconal Hospital: 'The use of force in psychiatric treatment, focusing on the legal amendments that enter into force on 1 September 2017'
4 September	Meeting of the advisory committee to the National Preventive Mechanism
4 September	Conference on women under the responsibility of the Correctional Service, organised by the Correctional Service of Norway Staff Academy (KRUS)
5 September	Meeting with Mari Bræin of RVTS Øst (the Eastern Norway regional resource centre for violence, traumatic stress and suicide prevention) on trauma sensitivity in child welfare
6 September	Women's Conference organised by the Correctional Service of Norway Staff Academy (KRUS)
8 September	Learning visit to Lovisenberg Hospital
22–24 September	The Norwegian Judicial Policy Association's autumn seminar 2017
25 September	Gave a talk to Tvangslovsutvalget – the committee tasked with assessing the rules on coercion in the healthcare sector
26 September	Meeting with Mads Harlem and Charlotte Bayegan-Harlem of the international law division of the Norwegian Red Cross
26 September	Breakfast seminar organised by the Ombudsman for Children on its report to the UN Committee on the Rights of the Child and children's right to be heard
26 September	Visit by a delegation from Nepal
29 September	Seminar organised by the Health and Social Services Ombudsman in Hedmark and Oppland: 'Due process protection for patients in mental health care'
2 October	Talk on Norway's experience of prevention work at a seminar in Dublin, organised by the Irish Human Rights and Equality Commission
4 October	Workshop at the office of the Norwegian Police Directorate on child welfare and the police
10 October	Meeting with the Ministry of Health and Care Services

WHEN	ACTIVITY
25 October	Meeting with Jörg Pont, international expert on the role of health personnel in relation to people deprived of their liberty
26 October	The Parliamentary Ombudsman's Human Rights Seminar 2017: 'The role of health personnel in relation to people deprived of their liberty in police custody facilities and prisons'
31 October	Meeting with Advocate Else McClimans and Aurora – support group for people with mental health problems
1 November	The Norwegian National Human Rights Institution and the Equality and Anti-Discrimination Ombudsman organised a preparatory meeting prior to the examination of Norway by the UN Committee on the Elimination of All Forms of Discrimination against Women (CEDAW)
1 November	Talk to the heads of the Correctional Service's supervisory councils (KDI/KRUS)
1 November	Lecture to the County Governor of Oslo and Akershus on health services in prison
16–17 November	Talk at the annual Supervisory Commission Conference
21 November	Talk at a seminar on the police custody system
22 November	Lucy Smith's Children's Rights Day: 'Children's right to development'
1 December	Attended the institution conference on child welfare, organised by the County Governor of Oslo and Akershus
4 December	Talk at a meeting for heads of units organised by the Norwegian Correctional Service
4 December	Meeting of the advisory committee to the National Preventive Mechanism
6 December	Meeting of the advisory committee to the Norwegian National Human Rights Institution (NIM)
8 December	Lecture to the R&D department at Akershus University Hospital (Ahus)
8 December	Lecture to the Norwegian Parliamentary Intelligence Oversight Committee on work methods
11–13 December	Study visit, organised by the Nordic Council, from representatives of Estonia's Chancellor of Justice
12 December	Lecture to doctors in specialist training at the University of Oslo: 'Human rights; their place in mental health care?'
13 December	Talk at the Equality and Anti-Discrimination Ombudsman's seminar on the use of force in relation to people with disabilities
14 December	Meeting with researcher Gro Ulset of the Norwegian University of Science and Technology (NTNU) – lecture and workshop on child welfare
15 December	Meeting with the Norwegian Board of Health Supervision on visits to child welfare institutions
15 December	Meeting with the Ombudsman for Children on visits to child welfare institutions



Alta, September 2017.

Budget and accounts 2017¹

CATEGORY	BUDGET 2017	ACCOUNTS 2017
SALARIES	6,840,000.00	6,534,500.67
OPERATING EXPENSES	4,160,000.00	
Furniture and equipment		48,600.19
Production and printing of visit reports, the annual report and informational materials		436,816.20
Procurement of external services (including translation and interpretation services)		265,668.25
Travel (visits and meetings)		400,868.95
Other operations		427,198.08
Share of the Parliamentary Ombudsman's shared costs (including IT services, rent, electricity, cleaning, security etc.)		2,244,975.41
TOTAL NOK	11,000,000.00	10,358,627.75

¹ This is included in the Parliamentary Ombudsman's budget and accounts, which are published in Document 4 (2017-2018).

Texts of acts

UN Convention against Torture

(selected articles)

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Article 1

1. For the purposes of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

2. This article is without prejudice to any international instrument or national legislation which does or may contain provisions of wider application.

Article 2

1. Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.

2. No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.

3. An order from a superior officer or a public authority may not be invoked as a justification of torture.

Article 3

1. No State Party shall expel, return ("refouler") or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture.

2. For the purpose of determining whether there are such grounds, the competent authorities shall take into account all relevant considerations including, where applicable, the existence in the State concerned of a consistent pattern of gross, flagrant or mass violations of human rights.

Article 4

1. Each State Party shall ensure that all acts of torture are offences under its criminal law. The same shall apply to an attempt to commit torture and to an act by any person which constitutes complicity or participation in torture. 2. Each State Party shall make these offences punishable by appropriate penalties which take into account their grave nature.

Article 5

1. Each State Party shall take such measures as may be necessary to establish its jurisdiction over the offences referred to in article 4 in the following cases:

- (a) When the offences are committed in any territory under its jurisdiction or on board a ship or aircraft registered in that State;
- (b) When the alleged offender is a national of that State;
- (c) When the victim is a national of that State if that State considers it appropriate.

2. Each State Party shall likewise take such measures as may be necessary to establish its jurisdiction over such offences in cases where the alleged offender is present in any territory under its jurisdiction and it does not extradite him pursuant to article 8 to any of the States mentioned in paragraph 1 of this article.

3. This Convention does not exclude any criminal jurisdiction exercised in accordance with internal law.

Article 6

1. Upon being satisfied, after an examination of information available to it, that the circumstances so warrant, any State Party in whose territory a person alleged to have committed any offence referred to in article 4 is present shall take him into custody or take other legal measures to ensure his presence. The custody and other legal measures shall be as provided in the law of that State but may be continued only for such time as is necessary to enable any criminal or extradition proceedings to be instituted.

2. Such State shall immediately make a preliminary inquiry into the facts.

3. Any person in custody pursuant to paragraph 1 of this article shall be assisted in communicating immediately with the nearest appropriate representative of the State of which he is a national, or, if he is a stateless person, with the representative of the State where he usually resides.

4. When a State, pursuant to this article, has taken a person into custody, it shall immediately notify the States referred to in article 5, paragraph 1, of the fact that such person is in custody and of the circumstances which warrant his detention. The State which makes the preliminary inquiry contemplated in paragraph 2 of this article shall promptly report its findings to the said States and shall indicate whether it intends to exercise jurisdiction.

Article 7

1. The State Party in the territory under whose jurisdiction a person alleged to have committed any offence referred to in article 4 is found shall in the cases contemplated in article 5, if it does not extradite him, submit the case to its competent authorities for the purpose of prosecution.

2. These authorities shall take their decision in the same manner as in the case of any ordinary offence of a serious nature under the law of that State. In the cases referred to in article 5, paragraph 2, the standards of evidence required for prosecution and conviction shall in no way be less stringent than those which apply in the cases referred to in article 5, paragraph 1.

3. Any person regarding whom proceedings are brought in connection with any of the offences referred to in article 4 shall be guaranteed fair treatment at all stages of the proceedings. (Articles 8-9)

Article 10

1. Each State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment.

2. Each State Party shall include this prohibition in the rules or instructions issued in regard to the duties and functions of any such person.

Article 11

Each State Party shall keep under systematic review interrogation rules, instructions, methods and practices as well as arrangements for the custody and treatment of persons subjected to any form of arrest, detention or imprisonment in any territory under its jurisdiction, with a view to preventing any cases of torture.

Article 12

Each State Party shall ensure that its competent authorities proceed to a prompt and impartial investigation, wherever there is reasonable ground to believe that an act of torture has been committed in any territory under its jurisdiction.

Article 13

Each State Party shall ensure that any individual who alleges he has been subjected to torture in any territory under its jurisdiction has the right to complain to, and to have his case promptly and impartially examined by, its competent authorities. Steps shall be taken to ensure that the complainant and witnesses are protected against all ill-treatment or intimidation as a consequence of his complaint or any evidence given.

Article 14

1. Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation.

2. Nothing in this article shall affect any right of the victim or other persons to compensation which may exist under national law.

Article 15

Each State Party shall ensure that any statement which is established to have been made as a result of torture shall not be invoked as evidence in any proceedings, except against a person accused of torture as evidence that the statement was made.

Article 16

1. Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.

2. The provisions of this Convention are without prejudice to the provisions of any other international instrument or national law which prohibits cruel, inhuman or degrading treatment or punishment or which relates to extradition or expulsion. (Articles 17-33)

The Optional Protocol to the Convention against Torture

(selected articles)

Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

PART I General principles

Article 1

The objective of the present Protocol is to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

Article 2

1. A Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of the Committee against Torture (hereinafter referred to as the Subcommittee on Prevention) shall be established and shall carry out the functions laid down in the present Protocol.

2. The Subcommittee on Prevention shall carry out its work within the framework of the Charter of the United Nations and shall be guided by the purposes and principles thereof, as well as the norms of the United Nations concerning the treatment of people deprived of their liberty.

3. Equally, the Subcommittee on Prevention shall be guided by the principles of confidentiality, impartiality, non-selectivity, universality and objectivity.

4. The Subcommittee on Prevention and the States Parties shall cooperate in the implementation of the present Protocol.

Article 3

Each State Party shall set up, designate or maintain at the domestic level one or several visiting bodies for the prevention of torture and other cruel, inhuman or degrading treatment or punishment (hereinafter referred to as the national preventive mechanism).

Article 4

1. Each State Party shall allow visits, in accordance with the present Protocol, by the mechanisms referred to in articles 2 and

3 to any place under its jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence (hereinafter referred to as places of detention). These visits shall be undertaken with a view to strengthening, if necessary, the protection of these persons against torture and other cruel, inhuman or degrading treatment or punishment.

2. For the purposes of the present Protocol, deprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.

PART II Subcommittee on Prevention

Article 5

1. The Subcommittee on Prevention shall consist of ten members. After the fiftieth ratification of or accession to the present Protocol, the number of the members of the Subcommittee on Prevention shall increase to twenty-five.

2. The members of the Subcommittee on Prevention shall be chosen from among persons of high moral character, having proven professional experience in the field of the administration of justice, in particular criminal law, prison or police administration, or in the various fields relevant to the treatment of persons deprived of their liberty.

3. In the composition of the Subcommittee on Prevention due consideration shall be given to equitable geographic distribution and to the representation of different forms of civilization and legal systems of the States Parties.

4. In this composition consideration shall also be given to balanced gender representation on the basis of the principles of equality and non-discrimination.

5. No two members of the Subcommittee on Prevention may be nationals of the same State.

6. The members of the Subcommittee on Prevention shall serve in their individual capacity, shall be independent and impartial and shall be available to serve the Subcommittee on Prevention efficiently.

(Articles 6-10)

PART III

Mandate of the Subcommittee on Prevention

Article 11

1. The Subcommittee on Prevention shall:
- (a) Visit the places referred to in article 4 and make recommendations to States Parties concerning the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment;
 - (b) In regard to the national preventive mechanisms:
 - (i) Advise and assist States Parties, when necessary, in their establishment;
 - (ii) Maintain direct, and if necessary confidential, contact with the national preventive mechanisms and offer them training and technical assistance with a view to strengthening their capacities;
 - (iii) Advise and assist them in the evaluation of the needs and the means necessary to strengthen the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment;
 - (iv) Make recommendations and observations to the States Parties with a view to strengthening the capacity and the mandate of the national preventive mechanisms for the prevention of torture and other cruel, inhuman or degrading treatment or punishment;
 - (c) Cooperate, for the prevention of torture in general, with the relevant United Nations organs and mechanisms as well as with the international, regional and national institutions or organizations working towards the strengthening of the protection of all persons against torture and other cruel, inhuman or degrading treatment or punishment.

Article 12

In order to enable the Subcommittee on Prevention to comply with its mandate as laid down in article 11, the States Parties undertake:

- (a) To receive the Subcommittee on Prevention in their territory and grant it access to the places of detention as defined in article 4 of the present Protocol;
- (b) To provide all relevant information the Subcommittee on Prevention may request to evaluate the needs and measures that should be adopted to strengthen the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment;
- (c) To encourage and facilitate contacts between the Subcommittee on Prevention and the national preventive mechanisms;
- (d) To examine the recommendations of the Subcommittee on Prevention and enter into dialogue with it on possible implementation measures.

Article 13

1. The Subcommittee on Prevention shall establish, at first by lot, a programme of regular visits to the States Parties in order to fulfil its mandate as established in article 11.
2. After consultations, the Subcommittee on Prevention shall notify the States Parties of its programme in order that they may, without delay, make the necessary practical arrangements for the visits to be conducted.
3. The visits shall be conducted by at least two members of the Subcommittee on Prevention. These members may be accompanied, if needed, by experts of demonstrated professional experience and knowledge in the fields covered by the present Protocol who shall be selected from a roster of experts prepared on the basis of proposals made by the States Parties, the Office of the United Nations High Commissioner for Human Rights and the United Nations Centre for International Crime Prevention. In preparing the roster, the States Parties concerned shall propose no more than five national experts. The State Party concerned may oppose the inclusion of a specific expert in the visit, whereupon the Subcommittee on Prevention shall propose another expert.
4. If the Subcommittee on Prevention considers it appropriate, it may propose a short follow-up visit after a regular visit.

Article 14

1. In order to enable the Subcommittee on Prevention to fulfil its mandate, the States Parties to the present Protocol undertake to grant it:
 - (a) Unrestricted access to all information concerning the number of persons deprived of their liberty in places of detention as defined in article 4, as well as the number of places and their location;
 - (b) Unrestricted access to all information referring to the treatment of those persons as well as their conditions of detention;
 - (c) Subject to paragraph 2 below, unrestricted access to all places of detention and their installations and facilities;
 - (d) The opportunity to have private interviews with the persons deprived of their liberty without witnesses, either personally or with a translator if deemed necessary, as well as with any other person who the Subcommittee on Prevention believes may supply relevant information;
 - (e) The liberty to choose the places it wants to visit and the persons it wants to interview.

2. Objection to a visit to a particular place of detention may be made only on urgent and compelling grounds of national defence, public safety, natural disaster or serious disorder in the place to be visited that temporarily prevent the carrying out of such a visit. The existence of a declared state of emergency as such shall not be invoked by a State Party as a reason to object to a visit.

Article 15

No authority or official shall order, apply, permit or tolerate any sanction against any person or organization for having communicated to the Subcommittee on Prevention or to its delegates any information, whether true or false, and no such person or organization shall be otherwise prejudiced in any way.

Article 16

1. The Subcommittee on Prevention shall communicate its recommendations and observations confidentially to the State Party and, if relevant, to the national preventive mechanism.

2. The Subcommittee on Prevention shall publish its report, together with any comments of the State Party concerned, whenever requested to do so by that State Party. If the State Party makes part of the report public, the Subcommittee on Prevention may publish the report in whole or in part. However, no personal data shall be published without the express consent of the person concerned.

3. The Subcommittee on Prevention shall present a public annual report on its activities to the Committee against Torture.

4. If the State Party refuses to cooperate with the Subcommittee on Prevention according to articles 12 and 14, or to take steps to improve the situation in the light of the recommendations of the Subcommittee on Prevention, the Committee against Torture may, at the request of the Subcommittee on Prevention, decide, by a majority of its members, after the State Party has had an opportunity to make its views known, to make a public statement on the matter or to publish the report of the Subcommittee on Prevention.

PART IV National preventive mechanisms

Article 17

Each State Party shall maintain, designate or establish, at the latest one year after the entry into force of the present Protocol or of its ratification or accession, one or several independent national preventive mechanisms for the prevention of torture at the domestic level. Mechanisms established by decentralized units may be designated as national preventive mechanisms for the purposes of the present Protocol if they are in conformity with its provisions.

Article 18

1. The States Parties shall guarantee the functional independence of the national preventive mechanisms as well as the independence of their personnel.

2. The States Parties shall take the necessary measures to ensure that the experts of the national preventive mechanism have the required capabilities and professional knowledge. They shall strive for a gender balance and the adequate representation of ethnic and minority groups in the country.

3. The States Parties undertake to make available the necessary resources for the functioning of the national preventive mechanisms.

4. When establishing national preventive mechanisms, States Parties shall give due consideration to the Principles relating to the status of national institutions for the promotion and protection of human rights.

Article 19

The national preventive mechanisms shall be granted at a minimum the power:

- (a) To regularly examine the treatment of the persons deprived of their liberty in places of detention as defined in article 4, with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment;
- (b) To make recommendations to the relevant authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty and to prevent torture and other cruel, inhuman or degrading treatment or punishment, taking into consideration the relevant norms of the United Nations;
- (c) To submit proposals and observations concerning existing or draft legislation.

Article 20

In order to enable the national preventive mechanisms to fulfil their mandate, the States Parties to the present Protocol undertake to grant them:

- (a) Access to all information concerning the number of persons deprived of their liberty in places of detention as defined in article 4, as well as the number of places and their location;
- (b) Access to all information referring to the treatment of those persons as well as their conditions of detention;
- (c) Access to all places of detention and their installations and facilities;
- (d) The opportunity to have private interviews with the persons deprived of their liberty without witnesses, either personally or with a translator if deemed necessary, as well as with any other person who the national preventive mechanism believes may supply relevant information;
- (e) The liberty to choose the places they want to visit and the persons they want to interview;
- (f) The right to have contacts with the Subcommittee on Prevention, to send it information and to meet with it.

Article 21

1. No authority or official shall order, apply, permit or tolerate any sanction against any person or organization for having communicated to the national preventive mechanism any information, whether true or false, and no such person or organization shall be otherwise prejudiced in any way.

2. Confidential information collected by the national preventive mechanism shall be privileged. No personal data shall be published without the express consent of the person concerned.

Article 22

The competent authorities of the State Party concerned shall examine the recommendations of the national preventive mechanism and enter into a dialogue with it on possible implementation measures.

Article 23

The States Parties to the present Protocol undertake to publish and disseminate the annual reports of the national preventive mechanisms.

(Articles 24-34)

Article 35

Members of the Subcommittee on Prevention and of the national preventive mechanisms shall be accorded such privileges and immunities as are necessary for the independent exercise of their functions. Members of the Subcommittee on Prevention shall be accorded the privileges and immunities specified in section 22 of the Convention on the Privileges and Immunities of the United Nations of 13 February 1946, subject to the provisions of section 23 of that Convention.

(Articles 36-37)

Act relating to the Parliamentary Ombudsman for Public Administration (the Parliamentary Ombudsman Act)

(selected sections)

Act of 22 June 1962 No. 8 as subsequently amended, most recently by Act of 21 June 2013 No. 89.

Section 1. Election of the Ombudsman

After each general election, the Storting elects a Parliamentary Ombudsman for Public Administration, the Parliamentary Ombudsman. The Ombudsman is elected for a term of four years reckoned from 1 January of the year following the general election.

The Ombudsman must satisfy the conditions for appointment as a Supreme Court Judge. He must not be a member of the Storting.

If the Ombudsman dies or becomes unable to discharge his duties, the Storting will elect a new Ombudsman for the remainder of the term of office. The same applies if the Ombudsman relinquishes his office, or if the Storting decides by a majority of at least two thirds of the votes cast to deprive him of his office.

If the Ombudsman is temporarily unable to discharge his duties because of illness or for other reasons, the Storting may elect a person to act in his place during his absence. In the event of absence for a period of up to three months, the Ombudsman may authorise the Head of Division to act in his place.

If the Presidium of the Storting finds that the Ombudsman is disqualified to deal with a particular matter, it will elect a substitute Ombudsman to deal with the matter in question.

Section 2. Instructions

The Storting will issue general instructions for the activities of the Ombudsman. Apart from this the Ombudsman is to discharge his duties autonomously and independently of the Storting.

Section 3. Purpose

As the Storting's representative, the Ombudsman shall, as prescribed in this Act and in his instructions, endeavour to ensure that individual citizens are not unjustly treated by the public administration and help to ensure that the public administration respects and safeguards human rights.

Section 3a. National preventive mechanism

The Ombudsman is the national preventive mechanism as described in Article 3 of the Optional Protocol of 18 December 2002 to the UN Convention of 10 December 1984 against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Section 4. Sphere of responsibility

The Ombudsman's sphere of responsibility encompasses the public administration and all persons engaged in its service. It also encompasses the conditions of detention for persons deprived of their liberty in private institutions when the deprivation of liberty is based on an order given by a public authority or takes place at the instigation of a public authority or with its consent or acquiescence.

The sphere of responsibility of the Ombudsman does not include:

- a) matters on which the Storting has reached a decision,
- b) decisions adopted by the King in Council,
- c) the activities of the courts of law,
- d) the activities of the Auditor General,
- e) matters that, as prescribed by the Storting, come under the Ombudsman's Committee or the Parliamentary Ombudsman for the Norwegian Armed Forces,
- f) decisions that as provided by statute may only be made by a municipal council, county council or cooperative municipal council itself, unless the decision is made by a municipal executive board, a county executive board, a standing committee, or a city or county government under section 13 of the Act of 25 September 1992 No. 107 concerning municipalities and county authorities. The Ombudsman may nevertheless investigate any such decision on his own initiative if he considers that it is required in the interests of due process of law or for other special reasons.

In its instructions for the Ombudsman, the Storting may establish:

- a) whether specific public institutions or enterprises shall be regarded as belonging to the public administration or a part of the services of the state, the municipalities or the county authorities under this Act,
- b) that certain parts of the activity of a public agency or a public institution shall fall outside the sphere of the Ombudsman's responsibility.

(Sections 5-6)

Section 7. Right to information

The Ombudsman may require public officials and all others engaged in the service of the public administration to provide him with such information as he needs to discharge his duties. As the national preventive mechanism, the Ombudsman has a corresponding right to require information from persons in the service of private institutions such as are mentioned in section 4, first paragraph, second sentence. To the same extent he may require that minutes/records and other documents are produced.

The Ombudsman may require the taking of evidence by the courts of law, in accordance with the provisions of section 43, second paragraph, of the Courts of Justice Act. The court hearings are not open to the public.

Section 8. Access to premises, places of service, etc

The Ombudsman is entitled to access to places of service, offices and other premises of any administrative agency and any enterprise that comes within his sphere of responsibility.

Section 9. Access to documents and duty of confidentiality

The Ombudsman's case documents are public. The Ombudsman will make the final decision on whether a document is to be wholly or partially exempt from access. Further rules, including on the right to exempt documents from access, will be provided in the instructions to the Ombudsman.

The Ombudsman has a duty of confidentiality as regards information concerning matters of a personal nature to which he becomes party to during the course of his duties. The duty of confidentiality also applies to information concerning operational and commercial secrets, and information that is classified under the Security Act or the Protection Instructions. The duty of confidentiality continues to apply after the Ombudsman has left his position. The same duty of confidentiality applies to his staff and others who provide assistance.

Section 10. Completion of the Ombudsman's procedures in a case

The Ombudsman is entitled to express his opinion on matters within his sphere of responsibility.

The Ombudsman may call attention to errors that have been committed or negligence that has been shown in the public administration. If he finds sufficient reason for so doing, he may inform the prosecuting authority or appointments authority of what action he believes should be taken in this connection

against the official concerned. If the Ombudsman concludes that a decision must be considered invalid or clearly unreasonable or that it clearly conflicts with good administrative practice, he may express this opinion. If the Ombudsman believes that there is reasonable doubt relating to factors of importance in the case, he may make the appropriate administrative agency aware of this.

If the Ombudsman finds that there are circumstances that may entail liability to pay compensation, he may, depending on the situation, suggest that compensation should be paid.

The Ombudsman may let a case rest when the error has been rectified or with the explanation that has been given.

The Ombudsman shall notify the complainant and others involved in a case of the outcome of his handling of the case. He may also notify the superior administrative agency concerned.

The Ombudsman himself will decide whether, and if so in what manner, he will inform the public of his handling of a case.

As the national preventive mechanism, the Ombudsman may make recommendations with the aim of improving the treatment and the conditions of persons deprived of their liberty and of preventing torture and other cruel, inhuman or degrading treatment or punishment. The competent authority shall examine the recommendations and enter into a dialogue with the Ombudsman on possible implementation measures.

Section 11. Notification of shortcomings in legislation and in administrative practice

If the Ombudsman becomes aware of shortcomings in acts, regulations or administrative practice, he may notify the ministry concerned to this effect.

Section 12. Reporting to the Storting

The Ombudsman shall submit an annual report on his activities to the Storting. A report shall be prepared on the Ombudsman's activities as the national preventive mechanism. The reports will be printed and published.

The Ombudsman may when he considers it appropriate submit special reports to the Storting and the relevant administrative agency.

(Sections 13-15)

Instructions for the Parliamentary Ombudsman for Public Administration

(selected sections)

Adopted by the Storting on 19 February 1980 under section 2 of the Act of 22 June 1962 No. 8 relating to the Parliamentary Ombudsman for Public Administration.

Section 1. Purpose

(See section 3 of the Parliamentary Ombudsman Act)

The Parliamentary Ombudsman for Public Administration shall seek to ensure that individual citizens are not unjustly treated by the public administration and that senior officials, officials and others engaged in the service of the public administration do not make errors or neglect their duties.

Section 2. Sphere of responsibility

(See section 4 of the Parliamentary Ombudsman Act)

The Norwegian Parliamentary Intelligence Oversight Committee shall not be considered as part of the public administration for the purposes of the Parliamentary Ombudsman Act. The Ombudsman shall not consider complaints concerning the intelligence, surveillance and security services that the Committee has already considered.

The Ombudsman shall not consider complaints about cases dealt with by the Storting's ex gratia payments committee.

The exception for the activities of the courts of law under section 4, first paragraph, c), also includes decisions that may be brought before a court by means of a complaint, appeal or other judicial remedy.

Amended by Storting decisions of 22 October 1996 No. 1479, 2 December 2003 No. 1898 (in force from 1 January 2004), 17 June 2013 No. 1251 (in force from 1 July 2013).

(Sections 3-8)

Section 8a. Special provisions relating to the Parliamentary Ombudsman as national preventive mechanism

The Ombudsman may receive assistance from persons with specific expertise in connection with its function as the national preventive mechanism in accordance with section 3a of the Parliamentary Ombudsman Act.

The Ombudsman shall establish an advisory committee to provide expertise, information, advice and input in connection with its function as the national preventive mechanism.

The advisory committee shall include members with expertise on children, human rights and psychiatry. The committee must have a good gender balance and each sex shall be represented by a minimum of 40 % of the membership. The committee may include both Norwegian and foreign members.

Added by Storting decision of 17 June 2013 No. 1251 (in force from 1 July 2013).

(Sections 9-11)

Section 12. Annual report to the Storting

(See section 12 of the Parliamentary Ombudsman Act)

The Ombudsman's annual report to the Storting shall be submitted by 1 April each year and shall cover the Ombudsman's activities in the period 1 January–31 December of the previous year.

The report shall contain a summary of procedures in cases which the Ombudsman considers to be of general interest, and shall mention those cases in which he has called attention to shortcomings in acts, regulations or administrative practice, or has issued a special report under section 12, second paragraph, of the Parliamentary Ombudsman Act. In the annual report, the Ombudsman shall also provide information on activities to oversee and monitor that the public administration respects and safeguards human rights.

If the Ombudsman finds reason to do so, he may refrain from mentioning names in the report. The report shall in any case not include information that is subject to the duty of confidentiality.

The account of cases where the Ombudsman has expressed an opinion as mentioned in section 10, second, third and fourth paragraphs, of the Parliamentary Ombudsman Act, shall summarise any response by the relevant administrative body or official about the complaint, see section 6, first paragraph, third sentence.

A report concerning the Ombudsman's activities as the national preventive mechanism shall be issued before 1 April each year. This report shall cover the period 1 January–31 December of the previous year.

Amended by Storting decision of 14 June 2000 No. 1712 (in force from 1 January 2001), 12 June 2007 No. 1101 (in force from 1 July 2007), 17 June 2013 No. 1251 (in force from 1 July 2013).

(Section 13)



Decorations on the door of a prison cell.

Annex

The role of medical personnel in places of detention

– ethical dilemmas, dual loyalty and the importance of international standards

Presented as the Keynote Address at the Norwegian Parliamentary Ombudsman's Human Rights Seminar in Oslo, 26 October 2017

By Dr. Jörg Pont, Vienna, Austria

The normative basis for providing healthcare in prisons and any other places of detention can be outlined as:

- › **The right of everyone, including detained individuals, to the highest attainable standard of physical and mental health according to the International Covenant on Economic, Social and Cultural Rights from 1966¹ ;**
- › **The stipulation that persons deprived of their liberty retain all rights that are not lawfully taken away from them according to the European Prison Rules² ; and**
- › **Based on WHO statements^{3,4} that Prison Health is an important part of Public Health.**

Considering these clear basic norms, one might wonder why there is any need for additional considerations, rules and documents on healthcare ethics in prison in addition to the general healthcare ethics. However, providing healthcare in prison and other places of detention has some peculiarities that are typical for this setting and that pose particular challenges, as described below.

The role of medical personnel in providing healthcare in prison

Firstly, as a rule, the detained individual cannot choose his/her healthcare providers and the health of inmates is therefore the responsibility of the state, which, legally and/or de facto, took away their liberty of movement. Secondly, in prisons and other places of detention, two completely different tasks have to be performed by two different professional groups under the same roof:

1 United Nations: International Covenant on Economic, Social and Cultural Rights. <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>


2 European Prison Rules 2006, Council of Europe Publishing. http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

3 WHO, Moscow Declaration on Prison Health as Part of Public Health, 2003. <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/pre-2005/moscow-declaration-on-prison-health-as-part-of-public-health>

4 WHO, The Madrid Recommendation, 2010 http://www.euro.who.int/__data/assets/pdf_file/0012/111360/E93574.pdf?ua=1

the main task of the prison administration is detention where investigation, execution of sentence, safety and security and social rehabilitation are regulated by strict penitentiary laws, whereas the tasks of healthcare providers are maintenance of health, prevention of health disorders, detection and treatment of health disorders and individual care of patients according to medical ethics, which, in comparison to 'hard' penitentiary law is often regarded as 'soft' law.

As a consequence, healthcare ethics can and do come into conflict with prison realities: Confidentiality, privacy and patients' consent, which are all fundamental aspects of medical care, conflict with principles of custody such as 'security and safety first'. Access to and equivalence of quality of medical care is often hampered by a lack of resources, overcrowding and understaffing. The professional independence of the healthcare workers employed and paid by the prison administration is restricted or regarded as restricted. The importance of prison health and prisoners' health as set out by WHO in the Moscow Declaration 2003 has yet to gain public recognition and support. Preventive healthcare is a difficult task in prison, i.e. an environment that is pathogenic in itself: The risk of a number of diseases among prisoners (mental disorders, suicide, tuberculosis, hepatitis B and C, HIV/AIDS, drug misuse and dependency) can be caused by imprisonment itself or increased by it. Concepts of health promotion, such as assuming self-responsibility for health, are hindered in an environment of deprivation of autonomy and self-determination. Planning of aftercare or through-care is difficult due to the organisational separation of prisons from the general community.



The sole task of healthcare workers is the health and well-being of the inmates.

Prison inmates who cannot choose their doctor may find it difficult to trust a physician who is employed or contracted by the administration. They may question the doctor's confidentiality, professional independence and qualification.

Healthcare staff are likewise challenged by the peculiarities of providing healthcare in prison, such as how to manage confidentiality, privacy and patients' consent in prison and detention centres, the paradigm of 'total institutions'.⁵ Obtaining the inmates' trust, balancing professional relationships with inmates and custodial staff, coping with pressures and expectations from inmates and the prison administrations while maintaining professional independence are among the greatest demands put on healthcare professionals working in prisons.

Prison governors and custodial staff may have their own perspectives on the physician's role regarding safety and security, and on healthcare expenses. They may question whether medical confidentiality, patients' consent and the doctor's professional independence are compatible with safety and security in prison. They may ask prison physicians to certify inmates as fit for disciplinary punishment or ask for the doctor's support during intimate body searches and drug testing. In addition, they may question expensive medical care costs within paltry prison budgets.

Furthermore, the public often has no understanding of the importance of prison health for public health, and may ask why money should be spent on the healthcare of offenders in times of budget cuts in healthcare for 'decent' people in the community.

International standards and guidelines for providing healthcare in prison

To cope with these problems, to meet these conflicting demands and to avoid misunderstandings, it is essential that:

- › **physicians and healthcare workers caring for detainees stick to sound medical ethics and**
- › **medical ethics are made known, understood and accepted by the whole prison community, i.e. the prisoners and the prison administration.**

In the past decades, a number of internationally accepted standards and guidelines on prison healthcare ethics have been developed and issued by the United Nations^{6,7}, the Council of Europe^{8,9,10}, the World Medical Association (WMA)¹¹, the International Council of Nurses¹², Penal Reform International¹³ and Physicians for Human Rights¹⁴.

The essence of all these documents can be summarised as follows: The sole task of healthcare workers is the health and well-being of the inmates and this task has to be provided with free access to healthcare for all inmates while maintaining confidentiality and respect for the patient's autonomy, including preventive healthcare and humanitarian support based on clinical independence and professional competence.

Compliance with these principles and guidelines not only ensures the ethical conduct of healthcare professionals in prison, but also provides very tangible professional advantages such as promotion of the inmates' confidence in medical care in prison, confirmation of the doctor's medical professionalism and ethics, prevention of misunderstandings, guidance in conflict situations, quality assurance of the medical work and safeguarding against legal complaints.

Compliance with these principles and guidelines not only ensures the ethical conduct of healthcare professionals in prison, but also provides very tangible professional advantages.

- 6 Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians for the Protection of Detained Persons and Prisoners Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1982 www.cirp.org/library/ethics/UN-medical-ethics
- 7 The United Nations Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules) www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf
- 8 Council of Europe: The CPT standards CPT/Inf/E(2002) 1-Rev 2010 <http://www.cpt.coe.int/en/docsstandards.htm>
- 9 Council of Europe: Recommendation Rec (2006)2 on the European Prison Rules <https://wcd.coe.int/ViewDoc.jsp?id=955747>
- 10 Ethical and Organisational Aspects of Health Care in Prison. R (98) 7, 1998 <https://rm.coe.int/16804fb13c>
- 11 World Medical Association Policies <https://www.wma.net/policy/>
- 12 Int. Council of Nurses: Nurses' role in the care of detainees and prisoners. Adopted 1998, revised 2011 www.icn.ch/images/stories/documents/publications/position_statements/A13_Nurses_Role_Detainees_Prisoners.pdf
- 13 Penal Reform International: Making Standards Work. An international handbook on good prison practice. 2nd edition, 2001. www.penalreform.org/publications/making-standards-work-international-handbook-good-prison-practice
- 14 Physicians for Human Rights: Dual Loyalty and Human Rights in Health Professionals Practice. <http://physiciansforhumanrights.org/library/report-dualloyalty-2006.html>

Examples of ethical dilemmas

However, despite these guidelines, ethical dilemmas may remain that healthcare professionals must be aware of and that must be dealt with individually based on an ethical analysis, particularly with regard to patients' consent and medical confidentiality.

One example is a case where the prison doctor becomes aware of signs of ill-treatment or even torture of an inmate and the inmate does not consent to the case being reported for fear of reprisals. On the one hand, medical confidentiality and patient consent rules have to be strictly followed, but, on the other hand, everything must be done to prevent ill-treatment and torture. Even international documents provide different guidance:

The European Committee for Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) recommends reporting such cases even without the consent of the victim whereas the Istanbul Protocol¹⁵ and the WMA in its 2007 Resolution on the Responsibility of Physicians in the Documentation of Torture and Inhuman or Degrading Treatment or Punishment¹⁶ recommend seeking solutions that promote justice without breaching the individual's right to confidentiality and weighing the risk and potential danger to that individual patient against the benefits to the general prison population and the interests of society in preventing the perpetuation of abuse.

Therefore, healthcare professionals should be aware of the overlapping and, in part, conflicting roles both victims/patients and doctors may have in cases of alleged ill-treatment: the victim is patient and plaintiff and often the only witness, whereas the doctor must assume the roles of the treating healthcare professional and the evaluating expert, roles with different and possibly conflicting duties of confidentiality.

Another often quoted and extremely challenging example concerning patient consent is healthcare for hunger strikers in prison, leading to the following dilemma for care providers: what is more important: sanctity of life or a patient's autonomy? Although the WMA Malta Declaration¹⁷ provides good guidance, the course of action taken after a patient loses his/her capacity to decide ultimately rests with the individual treating physician.

Dual loyalty and how to mitigate the risks

In order to expediently handle these ethical dilemmas, it is essential that healthcare professionals can act without any undue influence and intervention from third parties in relation to their sole task; the health and well-being of the inmates based on professional and clinical independence, i.e. without the ethical conflict of dual loyalty. Dual loyalty has been defined as the clinical role conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party.^{18,19}

15 Office of the United Nations High Commissioner for Human Rights: The Istanbul Protocol <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>

16 WMA Resolution on the Responsibility of Physicians in the Documentation of Torture and Inhuman or Degrading Treatment or Punishment www.wma.net/policies-post/wma-resolution-on-the-responsibility-of-physicians-in-the-documentation-and-denunciation-of-acts-of-torture-or-cruel-or-inhuman-or-degrading-treatment

17 WMA Declaration of Malta on Hunger Strikers www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers

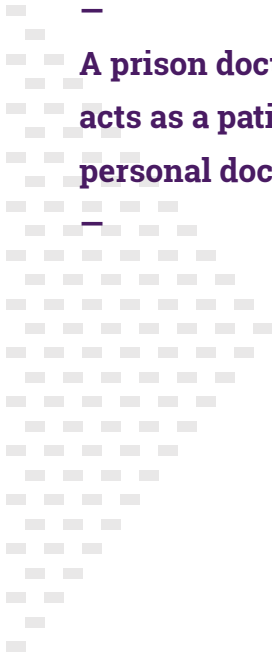
18 Physicians for Human Rights and School of Public Health and Primary HealthCare University of Cape Town, Health Sciences Faculty. Dual loyalty and human rights in health professional practice. Proposed guidelines and institutional mechanisms. March 2002. <http://physiciansforhumanrights.org/library/report-dualloyalty-2006.html>.

19 Pont J, Stöver H, Wolff H: Dual Loyalty in Prison Health Care. *American Journal of Public Health* 102:475-480, 2012 <http://ajph.aphapublications.org/doi/10.2105/AJPH.2011.300374>

The term was defined in 1982 in the UN Principles of Medical Ethics Relevant to the Role of Health Personnel in the Protection of Prisoners²⁰: 'It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health,' and, expressed in fewer words, in the CPT Standards²¹: 'A prison doctor acts as a patient's personal doctor'.

In order to reduce the risk of dual loyalty, two steps are essential. Firstly, the uncompromising separation of medical roles in prison, i.e. health professionals caring for prisoners should exclusively provide care based on professional independence. Medical functions in the interest of the state, prosecution, court or the security system are to be performed by health professionals not involved in the care of prisoners. Secondly, prison healthcare should be organised independently of prison authorities.²²

In the vast majority of European countries, prison healthcare governance is still under the responsibility of the same ministry that is responsible for the execution of detention or imprisonment, i.e. Ministries of Interior or Ministries of Justice or Corrections. It stands to reason that these administrations focus primarily on their main tasks and have less understanding and less expertise in healthcare issues. Norway with its 'import model' and the Swiss canton of Geneva were pioneers in Europe, transferring healthcare governance from the Ministry of Justice to public healthcare administrations or the Ministry of Health. They were followed by France, the United Kingdom, Iceland, the Swiss cantons Vaud, Wallis and Neuchatel, Cyprus, Kosovo and recently Finland. A number of other European countries are planning such a shift or are still in the process of transition.



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**A prison doctor
acts as a patient's
personal doctor.**
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20 Office of the United Nations High Commissioner for Human Rights: UN Resolution 37/194, 1982 Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment <http://www.ohchr.org/EN/ProfessionalInterest/Pages/MedicalEthics.aspx>

21 The CPT Standards. www.coe.int/en/web/cpt/standards

22 WHO/UNODC. Good governance for prison health in the 21st century. A policy brief on the organization of prison health www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/Good-governance-for-prison-health-in-the-21st-century.pdf



Dr. Jörg Pont gave the keynote address for a full auditorium at the Parliamentary Ombudsman's human rights seminar on 26 October 2017.

In addition, awareness and training in medical ethics should be strengthened for healthcare professionals as well as for non-medical prison staff, and national professional boards and public health authorities should actively support and maintain an oversight of healthcare professionals. With respect to training, the revised web-based course *Doctors Working in Prison: Human Rights and Ethical Dilemmas*²³, designed by the Norwegian Medical Association and adopted by the WMA and the International Committee of the Red Cross, another Norwegian pilot project, can be recommended as well as the Council of Europe Publication *Prison Health Care and Medical Ethics*²⁴ and WHO Publication *Prisons and Health*.²⁵

Finally, many countries should strive to incorporate principles of medical ethics into penitentiary legislation and or adapt the legislation to medical ethics. In order to achieve this goal, greater efforts must be made to advocate for 'Prison Health is Public Health', to ensure the understanding of the public and politicians.

23 NWA/WMA/ICRC web-based course: *Doctors working in prison: Human rights and ethical dilemmas* <https://nettkurs.legeforeningen.no/enrol/index.php?id=39>

24 Lehtmetts A, Pont J: *Prison health care and medical ethics*. Council of Europe Publishing <https://book.coe.int/eur/en/penal-law-and-criminology/6882-pdf-prison-health-care-and-medical-ethics.html>

25 WHO Regional Office Europe: *Prisons and Health*. http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

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