SIVILOMBUDET
Norwegian Parliamentary Ombud

VISIT REPORT | no. 80

SUMMARY AND RECOMMENDATIONS

Ringerike prison

February 6.–8. 2024

National Preventive Mechanism against
Torture and Ill-Treatment

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I. The Parliamentary Ombud's prevention mandate

The prohibition on torture and other cruel, inhuman or degrading treatment or punishment is established in several international conventions that are binding for Norway.

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture), adopted in 1984, plays a central role in this. The same prohibition is also embodied in the UN International Covenant on Civil and Political Rights (Article 7), the UN Convention on the Rights of the Child (Article 37), the UN Convention on the Rights of Persons with Disabilities (Article 15) and the European Convention on Human Rights (Article 3). Norway has ratified all of these conventions.

People who have been deprived of their liberty are vulnerable to violations of the prohibition against torture and inhuman treatment, which is why the UN adopted an optional protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 2002.

The protocol requires that states establish bodies to ensure that persons who are deprived of their liberty are not subjected to torture and other cruel, inhuman or degrading treatment or punishment. The Parliamentary Ombud has established its own national preventive mechanism (NPM) in order to fulfil this mandate.[1]

The Parliamentary Ombud has access to all locations where persons are or may be deprived of their liberty. These range from prisons and police custody facilities to mental health care institutions and child welfare institutions. Visits are conducted with or without prior notice. The Parliamentary Ombud also has access to all necessary information of significance for how deprivation of liberty is implemented.

The risk of torture or inhuman treatment is affected by factors such as legal and institutional frameworks, physical conditions, training, resources, management and institutional culture.[2] Effective prevention work therefore requires a broad approach that does not focus exclusively on whether the situation complies with Norwegian law.

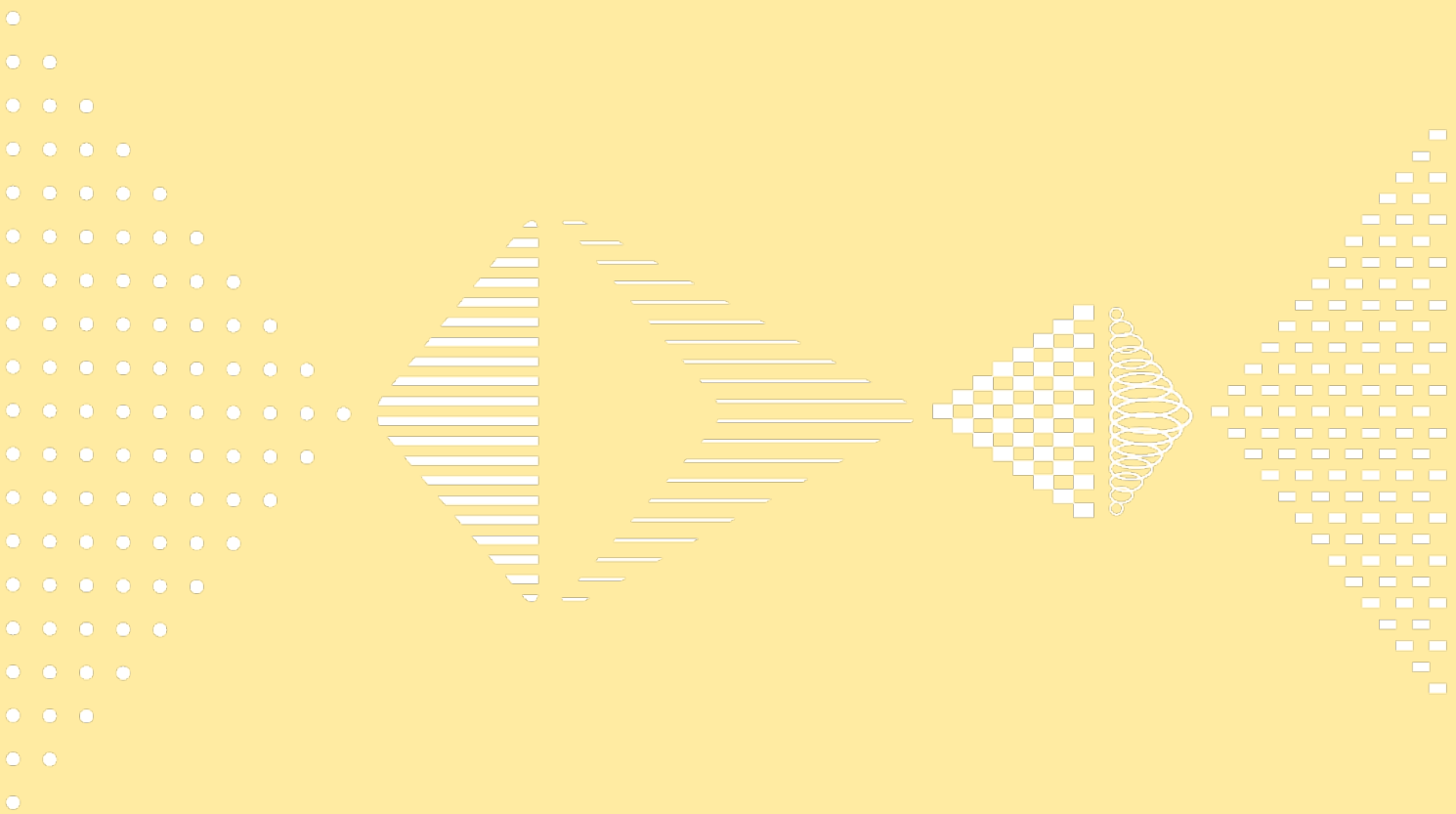
The Parliamentary Ombud’s assessments of conditions that pose a risk of torture and inhuman treatment are based on a broad range of sources. During the visits, the national preventive mechanism examines the conditions at the location through observations, interviews, and documentation reviews. Private interviews with persons deprived of their liberty are a particularly important source of first-hand information about the conditions. Interviews are also conducted with staff, management and other relevant parties and documentation is obtained to clarify the conditions at the location, such as guidelines, decisions, logs and health documentation.

After each visit, a report is written, describing findings and recommendations for how the facility in question can prevent torture and other cruel, inhuman or degrading treatment or punishment.

[1] Sections 1, 17, 18 and 19 of the Norwegian Parliamentary Ombud Act.
[2] UN Subcommittee on Prevention of Torture (SPT), Prevention Mandate Recommendations, 30 December 2010 CAT/OP/12/6.

The reports are published on the Parliamentary Ombud's website, and the facilities visited are given a deadline for informing the Ombud about their follow-up to the recommendations. These letters are also published.

In its endeavours to fulfil the prevention mandate, the Parliamentary Ombud also engages in extensive dialogue with national authorities, control and supervisory bodies in the public administration, civil society, and international human rights organisations.



II. Summary

The Parliamentary Ombud's Prevention Unit visited Ringerike Prison from February 6 to 8, 2024. Ringerike Prison is a high-security prison for men with 160 places. During the visit, 134 inmates were in the prison. Of these, 46 were on remand, 82 were convicted, and 6 had preventive detention sentences. Two of the detainees were placed in a department with a particularly high security level.

Challenging resource situation, insecurity, and confinement

The prison's resource situation appeared challenging. Several years of financial cuts have led to recruitment challenges and increased workloads for the remaining staff. Both management and staff expressed concerns about how this affects the services provided to inmates. The rise in violence and threats against staff was also concerning, with nearly a 50 per cent increase in incidents from 2022 to 2023, and a significant rise in serious incidents. An internal survey also revealed many unreported incidents.

The staff's ability to ensure inmates' safety was limited by low staffing levels, especially in communal wards and workshops. In the largest residential units, there could be only two officers responsible for up to 28 inmates, creating significant insecurity among some inmates. Several inmates reported threats of violence and exclusion. Inmates felt that staff could not protect them, and many isolated themselves in their cells out of fear for their safety. The Ombud is seriously concerned about the impact of low staffing levels on inmate safety and how this makes it more challenging to prevent isolation.

The prison did not have enough work opportunities for all inmates. Several inmates reported having to wait weeks or months for a daily activity program. Those without daily activities were locked up for up to 19 hours a day and experienced symptoms consistent with the harmful effects of isolation, such as hallucinations. Extensive confinement for indefinite periods, without individual assessment and a written decision, carries a risk of human rights violations. High levels of confinement also increase the risk of conflict and insecurity and weaken staff's ability to work towards fostering good relations with inmates, ensuring security, and doing reintegration work.

Need for strengthened legal safeguards and follow-up during isolation

Inmates isolated by court order or excluded from the community of other inmates by the prison administration were placed in Section A, the prison's restrictive unit. Inmates considered a danger to themselves or others, were isolated in one of the prison's security cells.

The prison's decisions on exclusion from the company of other inmates often lacked a description of whether less intrusive measures had been considered. Both exclusion decisions and security cell placements often lacked an assessment of whether the intervention was proportionate, meaning whether the need for isolation outweighed the negative consequences for the inmate.

There were no documented ongoing assessments of whether exclusion decisions could be lifted. We also uncovered significant weaknesses in the frequency and quality of ongoing assessments of security cell stays. This increased the risk that inmates would be isolated longer than strictly necessary.

An activity team, together with regular officers, was supposed to ensure that isolated inmates were offered at least two hours of meaningful human contact daily to prevent the harmful effects of isolation. The activity team did important work but lacked the capacity to offer a full program to all isolated inmates. Inmates in special security regimes in the restrictive unit were only monitored by officers in full protective gear, including helmets and shields, and at times, these inmates had to wear

handcuffs. These security measures made it practically impossible to ensure that such interactions could be experienced as meaningful for the inmate.

Need to prevent long-term isolation.

The number of long-term isolation cases has nearly doubled from 2022 to 2023. Long-term isolation particularly affected inmates who isolated themselves and those with mental health issues and challenging behaviour. The prison faced significant challenges in handling inmates with violence and aggression issues without isolation and intrusive security measures. Challenging behaviour was met with more restrictive security measures, which in turn led to increased resistance from inmates. This dynamic made it very challenging to carry out effective relationship-building and to work towards meaningful change.

During the visit, two inmates were isolated in so-called reinforced cells, with less furniture than regular cells. These inmates were also subject to a special security regime and had to be locked and escorted outside their cells by multiple officers in full protective gear. One inmate had, for a period, been required to wear handcuffs during all his movements outside the cell. Despite low staffing levels making it difficult to prevent isolation, the Ombud calls for measures that the prison can implement to prevent the use of isolation and coercive measures, even considering resource limitations. The Ombud specifically points out that the prison lacked individual plans describing how to work towards lifting the isolation. There is also a need to strengthen inmates' ability to participate and increase focus on conflict prevention skills.

Concern about the use of security cells in cases of suicide risk

The prison had the second-highest number of security cell cases among all men’s prisons in both 2022 and 2023. Of the 35 security cell decisions in 2023, 28 were implemented due to inmates’ suicide attempts, self-harm, or expressed wishes to take their own lives. It is highly concerning that security cells are used as a measure to prevent suicide.

The prison was asked to consider alternative ways of managing inmates at risk of suicide, such as closer follow-up with conversations, physical activity, and contact with clergy, healthcare personnel, and family members. The Ombud also recommended increasing inmates' access to free helplines.

Conditions for inmates in the special high-security department

Of the two inmates placed in a special high-security department, one had a fairly comprehensive daily program despite strict control measures. The other inmate had self-isolated for a long time and had declined most offers. There were also not enough officers to offer this inmate a satisfactory daily program. The Ombud is concerned that staffing limitations could lead to insufficient efforts to counteract self-isolation.

Deficiencies in health follow-up

The visit revealed serious deficiencies in the health follow-up of inmates who were subjected to isolation. The prison’s health department did not conduct daily visits to inmates with exclusion orders, as required by human rights standards. Some inmates had been excluded from the company of others for several weeks without documented follow-up from healthcare personnel. We also found instances where healthcare personnel did not follow up on inmates in security cells. Outside the health department’s opening hours, the emergency clinic was contacted to follow up on inmates in security cells, but the emergency clinic often failed to conduct checks in such situations.

Examples were also found where healthcare personnel from the emergency clinic advised the prison to place inmates in reinforced and security cells, which contradicts healthcare personnel's independent role.

III. Recommendations

Daily Activities

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

Safety

2. The prison should ensure better safety for both inmates and staff through increased presence of prison officers in communal areas.

Contact with the outside world.

3. The prison should strengthen inmates' opportunities for contact with the outside world. This especially applies to contact with friends and family, including in the afternoon and evening, through phone calls, video calls, and visits.
4. The prison should ensure that consideration of the best interests of the child is assessed in all cases of outside contact where the inmate's relatives are under 18 and that this is documented.

Time Outside the Cell

5. The prison should ensure that all inmates who are not formally isolated can spend at least eight hours outside their cell each day, engaging in meaningful activities.

Exclusion from the company of other inmates

6. The prison should ensure that decisions on exclusion are specifically justified. The decision should state why isolation was strictly necessary, that less intrusive measures were considered, and that the measure is proportionate.
7. The prison should ensure ongoing assessments to determine if it is strictly necessary to maintain an exclusion, and that these assessments are documented.
8. The prison should implement measures to strengthen internal control over exclusion decisions.

Follow-up of Isolated Inmates

9. The prison should continue working to ensure that all isolated individuals receive daily follow-up, with at least two hours of meaningful human contact as a minimum.

Inmates Isolated in Reinforced Cells

10. The prison should take measures to ensure that isolation in reinforced cells does not constitute a disproportionate measure.
11. The prison should ensure that exclusion decisions detail how they are to be implemented, and that additional restrictions and security measures are documented.
12. The prison should ensure that decisions are made for any planned use of handcuffs, including justification and the ability to appeal.

Measures to End Isolation

13. The prison should ensure that inmates at risk of prolonged isolation have individualized plans that facilitate reintegration into the community.

Use of Security Cells

14. The prison should ensure that all security cell placement decisions are specifically justified. The decision should show why isolation is strictly necessary, that less intrusive measures were considered, and that the measure is proportionate.

15. The prison should ensure ongoing assessments to determine if it is strictly necessary to maintain a security cell decision, and that these assessments are documented at least every six hours.

16. The prison should ensure that staff supervising security cells establish a dialogue with inmates as early as possible to prevent stays from lasting longer than strictly necessary. A decision-maker should be notified immediately if the situation requires reassessment.

17. The prison should ensure that inmates in security cells receive food and drink in a dignified manner, as far as possible without using a floor hatch.

18. The prison should ensure that inmates can contact their lawyer without delay and in full confidentiality while in a security cell.

Special High-Security Unit

19. The prison should ensure that only the operational chief officer carries pepper spray and that it is otherwise stored in the guardroom.

20. The prison should, in consultation with the regional level, ensure that the basic staffing of the unit is sufficient to provide all inmates with meaningful daily activities.

Prevention of Isolation and Coercive Measures

21. The prison should strengthen its work on preventing isolation and the use of coercive measures.

Self-harm, Suicide Attempts, and Suicide

22. The prison should ensure that inmates at heightened risk of suicide and self-harm are met with evidence-based prevention measures, such as increased human contact, care, and activities.

23. The prison should ensure that isolation is not used as a tool to prevent or manage suicide risk.

Organization and Cooperation in Healthcare Follow-Up

24. Ringerike Municipality, the prison, and Vestre Viken Hospital Trust should ensure that regular cooperation meetings are held at a management level.

25. Ringerike Municipality should ensure that there are written routines and procedures for the work of the healthcare department.

Initial Health Assessment

26. Ringerike Municipality should develop written procedures for health assessments upon entry.

27. Ringerike Municipality should ensure health needs assessments are conducted at entry, no later than 24 hours, even outside healthcare department hours.

28. Ringerike Municipality should ensure routine assessment and documentation of self-harm and suicide risk in the patient's record.

Appointments with Health Services

29. Ringerike Municipality and the prison should together ensure that inmates can quickly and directly contact the healthcare department without confidential health information being accessible to unauthorized individuals.

Medication Management

30. Ringerike Municipality, together with the prison, should ensure a system for proper medication management to strengthen patient safety and prevent the dissemination of health information.

Continuity of care

31. The prison and Ringerike Municipality should separately keep track of cancelled or postponed health service appointments and together ensure that inmates receive necessary health follow-up.

Health Follow-Up for Isolated Inmates

32. Ringerike Municipality should develop routines for following up on isolated inmates.

33. Ringerike Municipality should ensure daily monitoring and follow-up for isolated inmates, regardless of whether isolation was decided by the prison, full isolation ordered by the court, or self-isolation.

34. Ringerike Municipality should ensure a systematic and comprehensive overview of isolated inmates, including the reason for isolation, duration, any negative health effects, and health checks by healthcare personnel, including both healthcare departments and emergency services.

Healthcare Services' Professional Independence

35. Ringerike Municipality should ensure that all healthcare personnel following up on inmates in prison fully maintain their independence and never recommend or approve the prison's use of coercive measures.

36. The prison, Vestre Viken Hospital Trust, and Ringerike Municipality should jointly ensure that health assessments of inmates are conducted without prison officers overhearing confidential patient information.

Inmates with Extensive Health and Care Needs

37. The prison and Ringerike Municipality should make continuous assessments of the need for accommodations for inmates with extensive health and care needs to ensure that these accommodations are satisfactory and that the continued stay in prison is neither irresponsible nor undignified.

38. The prison should have specific routines for follow-up in cases where imprisonment appears disproportionately burdensome for individual inmates.

39. Ringerike Municipality should have specific routines for follow-up in cases where continued stay in prison is deemed medically inadvisable.

Office address: Akersgata 8, Oslo
Postal address: P.O. Box 3 Sentrum, NO-0101 Oslo
Telephone: +47 22 82 85 00
Free of charge: +47 800 80 039
Email: postmottak@sivilombudet.no
www.sivilombudet.no

Photo: Sivilombudet