SIVILOMBUDET
Norwegian Parliamentary Ombud

VISIT REPORT | no. 84

SUMMARY AND RECOMMENDATIONS

Stavanger Prison

September 17 to 19, 2024

National Preventive Mechanism against
Torture and Ill-Treatment

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Table of content

I. The Parliamentary Ombud's prevention mandate

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

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

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

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

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

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

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

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

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

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

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

II. Summary

The National Preventive Mechanism of the Parliamentary Ombud conducted a visit to Stavanger Prison from September 17 to 19, 2024. Stavanger Prison is a high-security facility for men with a capacity of 49 inmates.

Challenging Resource Situation, Lockdown, and Insecurity
The Parliamentary Ombud is concerned about the consequences of the resource and staffing situation at Stavanger Prison. The difficult financial situation has resulted in vacancies of several officer positions, and one of the prison's two communal wards has been temporarily closed. During our visit, the prison had one general communal ward for 14 inmates, while the prison's restrictive ward, in comparison, could house 22 inmates.

None of the inmates in the restrictive ward had a daily routine that met the international standard of at least eight hours outside of cell per day. Inmates in this ward who did not have a full-time work or education offer risked being locked in their cells for more than 19 hours a day.

The size of the restrictive ward and limited capacity in the communal ward meant that inmates could be confined to the restrictive ward for several months without this being justified by the individual circumstances of the inmate.

Long-term and extensive lockdown poses a risk of harmful effects on the inmates' health and increases the risk of conflict and insecurity among inmates. We found several cases of violence and insecurity among inmates that went unnoticed by the staff. At the same time, staff appeared to have a good and friendly attitude towards the inmates. They were easy to relate to, and our impression was that inmates found the staff supportive. However, we did find concrete health issues among inmates who had been locked up for extended periods, including symptoms of depression, weight loss, and fear of interacting with others.

Weaknesses in the Prison's Use of Solitary Confinement and Security Cells
The prison's decisions on solitary confinement and the use of security cells often lacked descriptions of what the measure was intended to address and whether less intrusive measures had been attempted. Furthermore, there were no assessments of the impact of the intervention on the individual or whether it was proportionate. The inmates' views on the situation were also not described in the decisions.

The prison did not sufficiently document continuous assessments of whether there were grounds to maintain solitary confinement of inmates. In one case, there were no documented assessments over a period of 25 days. We also uncovered serious weaknesses regarding the frequency and quality of ongoing assessments of whether placement in a security cell should be maintained. The Parliamentary Ombud is concerned that the weak assessments resulted in inmates being placed in solitary confinement or security cells longer than warranted.

Inmates in solitary confinement were attended to by the prison's activity team. However, neither the requirements for regular supervision by staff nor the requirement for at least two hours of meaningful human contact every day were always adhered to. In cases where inmates were held in solitary confinement based on their own requests, we found few concrete plans for reintegrating inmates into the prison community.

In two instances, inmates were placed in a security cell without having their handcuffs removed until several hours after the placement. In one of these cases, the inmate had just before the placement been sprayed with pepper spray through the small opening in a locked cell door. The prison had not described why this use of force was strictly necessary, and in our assessment, all three cases of force were in violation of the prohibition against inhuman and degrading treatment under Article 3 of the European Convention on Human Rights.

Weaknesses in Health Services and Suicide Prevention

The visit revealed serious deficiencies in the medical monitoring of isolated inmates. In many cases, it was not documented that the prison had notified the health department when inmates were placed in solitary confinement. The health department also did not carry out daily visits to inmates known to be isolated. Several isolated inmates did not receive any health supervision at all. In sum, these circumstances pose a high risk that inmates are not receiving necessary health follow-up in a highly vulnerable situation, which increases the risk of harmful effects on the inmates due to the isolation.

Even among inmates placed in security cells, we found cases where there was no documentation that health personnel had been notified or that inmates received any health supervision.

Despite good day-to-day cooperation between the health department and prison staff, we found little systematic and regular cooperation at the local management level between the health department, the specialized healthcare services, and the prison. The health department was, for instance, unaware of how much time some inmates spent alone in their cells.

There were also deficiencies in both the prison's and the health department's health assessments. The risk of suicide among inmates was not adequately assessed by either the prison or the health department upon intake, and it was unclear to what extent new risk assessments or action plans were developed after specific incidents in the prison.

Errors and lack of clarity in the Prison's Documentation

We found several instances of errors and lack of clarity in the prison's written documentation.

In one case, a reason for an inmate's exclusion was provided in the decision but a different reason appeared in the prison's journal system. In other cases, we found discrepancies between the how the prison referred to an inmate's statement when assessing the continuation of solitary confinement and the prison's own interrogation report from the same inmate. We also discovered weekly plans for an inmate in solitary confinement that were created retroactively, containing multiple errors and misleading information. In other instances, the prison failed to record information in several places, such as in an electronic journal system and in a log. In such cases, it was generally necessary to cross-reference all sources to get a complete picture of the situation.

These deficiencies pose a challenge to inmates' legal rights and have made it more difficult to monitor the prison's treatment of inmates.

III. Recommendations

Recommendation: Cooperation between the healthcare services and the correctional services

1. The prison, the municipality, and the hospital should strengthen their cooperation, particularly by ensuring a regular meeting structure between the parties at the local management level.

Recommendation: Everyday life in Stavanger Prison

2. The prison should ensure that all inmates can spend at least eight hours outside their cell every day.
3. The prison should, as far as possible, ensure that all inmates have access to daily activities such as work or education.
4. The prison should ensure that inmates have access to shelter from the weather in the exercise yard.
5. The prison should ensure better safety for inmates through increased presence of prison officers in communal areas.
6. The prison, municipality, and hospital should collaborate to implement health-promoting measures for inmates to prevent and reduce negative health consequences resulting from conditions in the prison.

Recommendation: Decisions on exclusion

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

Recommendation: Continuously assessments

8. The prison should ensure that the strict necessity of exclusion is continuously assessed, and that these assessments are documented in writing.

Recommendation: Monitoring of isolated inmates

9. The prison should strengthen its efforts to reduce the risk of harm caused by isolation and ensure that deviations are documented and followed up systematically.
10. The prison should continue its efforts to ensure that all inmates in isolation receive daily follow-up, with at least two hours of meaningful human contact offered.
11. The prison should ensure that inmates at risk of prolonged isolation have individualized plans that facilitate reintegration into the community.
12. The prison should ensure that healthcare personnel are notified without undue delay about inmates who have been placed in isolation by the court or are excluded from the community.

13. Stavanger Municipality should ensure daily supervision and follow-up for isolated inmates, and that this is documented in the inmate's medical record.

Recommendation: Need for improved internal control

14. The prison should implement measures to strengthen internal control over exclusion decisions.

Recommendation: Decisions on the use of security cells

15. The prison should ensure that all decisions regarding placement in security cells are made in accordance with the law, with a specific assessment showing that why the decision is strictly necessary, that less intrusive measures have been considered, and that the intervention is proportionate.
16. The prison should ensure that staff actively use conflict-reducing communication to prevent the use of isolation and coercive measures, and that staff receive relevant training
17. The prison should ensure that isolation is not used as a tool to prevent or manage suicide risk.

Recommendation: Ongoing assessments on the use of security cells

18. 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.
19. 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.

Recommendation: Monitoring of inmates in a security cell

20. Inmates in the security cell should be allowed contact with the outside world and time outdoors, especially if their placement exceeds 24 hours.
21. To prevent isolation and the use of coercive measures, the prison should conduct follow-up interviews with inmates who have been placed in a security cell.
22. The prison should ensure that a doctor is notified without unnecessary delay when an inmate is placed in a security cell.
23. The prison should ensure that inmates can wear their own clothes during their stay in the security cell, unless considerations for the inmates' own safety dictate the use of prison clothing.
24. The prison should immediately ensure that inmates are not placed in a security cell with handcuffs.

25. The prison should ensure that pepper spray is not used unless strictly necessary, and never through the hatch in the inmate's cell door.
26. The prison should implement measures to ensure that inmates who wish to contact a lawyer while placed in a security cell are able to do so without delay and in full confidentiality.
27. The Norwegian Correctional Service, Southwestern Region should ensure that they make independent assessments of whether the conditions for continued isolation are met, including the requirement that continued placement in a security cell must be proportionate.

Recommendation: Suicide prevention

29. The prison should strengthen its efforts to prevent suicide and self-harm, especially by ensure that suicide risk is reviewed and evaluated both upon admission and while the inmate is in prison
30. Stavanger Municipality should ensure that suicide risk is reviewed and evaluated both upon admission and while the inmate is in prison and ensure adequate record-keeping.

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