



CPT/Inf (2006) 14

**Report to the Norwegian Government  
on the visit to Norway  
carried out by the European Committee  
for the Prevention of Torture and Inhuman  
or Degrading Treatment or Punishment (CPT)**

**from 3 to 10 October 2005**

The Norwegian Government has requested the publication of this report.

Strasbourg, 11 April 2006

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**Copy of the letter transmitting the CPT's report**

Strasbourg, 28 March 2006

Dear Sir, Madam,

In pursuance of Article 10, paragraph 1, of the European Convention for the prevention of torture and inhuman or degrading treatment or punishment, I enclose herewith the report to the Government of Norway drawn up by the European Committee for the prevention of torture and inhuman or degrading treatment or punishment (CPT) following its visit to Norway from 3 to 10 October 2005. The report was adopted by the CPT at its 59<sup>th</sup> meeting, held from 6 to 10 March 2006.

The various recommendations, comments and requests for information formulated by the CPT are listed in Appendix I. As regards more particularly the CPT's recommendations, having regard to Article 10 of the Convention, the Committee requests the Norwegian authorities to provide **within six months** a response giving a full account of action taken to implement them. The CPT trusts that it will also be possible for the Norwegian authorities to provide, in the above-mentioned response, reactions to the comments formulated in this report which are summarised in Appendix I as well as replies to the requests for information made.

It would be most helpful if the Norwegian authorities could provide a copy of the response in a computer-readable form.

I am at your entire disposal if you have any questions concerning either the CPT's report or the future procedure.

Yours faithfully,

Silvia CASALE  
President of the European Committee for the  
prevention of torture and inhuman  
or degrading treatment or punishment

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## I. INTRODUCTION

### A. Dates of the visit and composition of the delegation

1. In pursuance of Article 7 of the European Convention for the prevention of torture and inhuman or degrading treatment or punishment (hereinafter referred to as "the Convention"), a delegation of the CPT carried out a visit to Norway from 3 to 10 October 2005. The visit formed part of the CPT's programme of periodic visits for 2005. It was the fourth visit to Norway to be carried out by the CPT.<sup>1</sup>

2. The visit was carried out by the following members of the CPT:

- Aleš BUTALA (Head of delegation)
- Pétur HAUSSON
- Isolde KIEBER
- Petros MICHAELIDES.

They were supported by Muriel ISELI and Edo KORLJAN of the CPT's Secretariat, and assisted by:

- Marianne KASTRUP, Psychiatrist, Rigshospitalet, Copenhagen, Denmark (expert)
- Bertel ÖSTERDAHL, former Director General of the National Prison and Probation Administration, Sweden (expert)
- Anne BRYN (interpreter)
- Karin HENDERSON (interpreter)
- Nina REIER (interpreter)
- Linda SIVESIND (interpreter).

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<sup>1</sup> The CPT's previous periodic visits to Norway took place in June/July 1993, March 1997 and September 1999. The CPT's reports on these visits, together with the responses of the Norwegian Government, have been published, for the 1993 visit, as documents CPT/Inf (94) 11, CPT/Inf (94) 12 and CPT/Inf (96) 16; for the 1997 visit, as documents CPT/Inf (97) 11 and CPT/Inf (98) 3; for the 1999 visit, as documents CPT/Inf (2000) 15, and CPT/Inf (2000) 16.

**B. Establishments visited**

3. The delegation visited the following places of detention:

Police establishments

- Oslo Police District Headquarters
- Trondheim Police Station
- Trandum Aliens Holding Centre

Prisons

- Ila Preventive and Security Detention Prison
- Ringerike Prison
- Trondheim Prison

Psychiatric Hospitals

- Sør-Trøndelag Psychiatric Hospital, Brøset, Trondheim

The delegation also went to Stavanger Prison with a view to meeting remand prisoners subject to very high security conditions of detention.

**C. Consultations and co-operation**

4. According to the standard practice, the delegation held consultations with the national authorities and, at local level, with the directors of the establishments visited and members of the various professional categories working there. It also met representatives of non-governmental organisations active in the areas of concern to the CPT.<sup>2</sup>

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<sup>2</sup> A list of the governmental authorities, other authorities and non-governmental organisations met by the delegation is set out in Appendix II to this report.

5. The co-operation of the Norwegian authorities with the delegation was in all respects exemplary.

The CPT is grateful to Odd Einar DØRUM, Minister of Justice and the Police, for the time he devoted to the talks with the delegation. There were also fruitful discussions with senior officials of the Ministries of Justice and the Police, of Health and Care Services, of Labour and Social Affairs, and of Local Government and Regional Development. Further, the delegation had interesting exchanges of views with Tor-Aksel BUSCH, Director General of Public Prosecutions, Arne FLIFLET, Parliamentary Ombudsman, and Reidar HJERMANN, Ombudsman for Children.

In addition, the CPT would like to express its appreciation for the valuable assistance given to its delegation, both during and after the visit, by the liaison officers appointed by the Norwegian authorities.

6. Further, the delegation received excellent co-operation from the directors and staff of the establishments visited, including those who had not received advance notification of a visit. In particular, the delegation was granted rapid access to all the establishments, to the prisoners and patients with whom it wished to speak, and to the information and documentation required to carry out its task.

In general, the delegation could see that the directors and staff of the establishments which it visited had been notified of the CPT's visit and were properly informed of its mandate and powers.

7. The principle of co-operation set out in Article 3 of the Convention also requires that the Parties take effective measures to implement the recommendations of the CPT. On this point, additional efforts by the Norwegian authorities are needed in some areas, particularly as concerns the right of access to a lawyer (cf. paragraphs 19 and 20).

## II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

### A. Police establishments

#### 1. Preliminary remarks

8. Since the visit carried out by the CPT in 1999, the Norwegian police service has undergone extensive reform,<sup>3</sup> and there have been several changes in the legal framework that regulates detention by the police.

Even so, the principal rules of police custody, summarised in the previous CPT reports,<sup>4</sup> were still valid at the time of the 2005 visit. In particular, persons deprived of their liberty by the police on suspicion of having committed a criminal offence should be brought "as soon as possible and not later than on the day following the arrest" before the magistrate competent to rule on, and, if necessary, order remand in custody. The delegation was nevertheless informed that the maximum duration of police custody was to be raised to 72 hours under an amendment to Section 183 of the Criminal Procedure Act (CPA) adopted in 2002 but not yet in force, as the implementing regulations were still in preparation.<sup>5</sup> The purpose of this amendment is to enable the police to conduct their investigation as soon as possible after perpetration of the offence; according to the Ministry of Justice and the prosecuting authorities, it will lead to a reduction in the number of cases in which remand in custody needs to be ordered.

**The CPT would like to be informed of the entry into force of Section 183 CPA and to receive in due course a copy of its implementing regulations.**

9. A person may also be held in a police establishment pursuant to the Police Act, for example, for disturbing the peace, refusing to obey an order issued by the police, for identification (for up to four hours) or to recover from intoxication.<sup>6</sup>

10. In its report on the visit made in 1999, the Committee was pleased to note a significant reduction in the average length of the time spent by remand prisoners on police premises, and recommended that the Norwegian authorities pursue their efforts in the matter. In their reply, the authorities indicated that, in a letter of 8 June 2000, the Ministry of Justice and the Police had informed prison directors that steps must be taken to ensure that remand prisoners were, as far as possible, transferred directly from the court to prison after their appearance, and that in all cases the transfer must be made not later than 24 hours after the decision ordering remand in custody.<sup>7</sup>

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<sup>3</sup> Cf. Parliamentary White Paper No. 22 - *Police reform 2000*.

<sup>4</sup> Cf. CPT/Inf (94) 11, paragraph 10, and CPT/Inf (2000) 15, paragraph 9.

<sup>5</sup> Under Section 183 of the amended CPA, appearance before the magistrate competent to order pre-trial detention must occur "as soon as possible and not later than on the third day following the arrest".

<sup>6</sup> Cf. Sections 8 and 9 of Police Act No. 53 of 4 August 1995.

<sup>7</sup> Cf. CPT/Inf (2000) 15, paragraph 14, and CPT/Inf (2000) 16, page 7.



During the 2005 visit, the delegation was informed that, under the terms of Section 4.1 of the Regulations to the Execution of Sentences Act,<sup>8</sup> the transfer of a prisoner from a police cell to a prison must be effected "without undue delay" once the remand decision has been taken,<sup>9</sup> and that the Norwegian authorities aimed - as in 1999 - to carry out the transfer within 24 hours following this decision ("24-hour rule"). Weekly checks took place; this rule was still not consistently observed but the situation was improving.<sup>10</sup> This was confirmed by the delegation's findings. Thus, at Trondheim police station, during the first half of 2005, the average time that elapsed between a person's arrival there and being transferred to a prison was 24 hours and 32 minutes, and the average time between the decision of the tribunal to remand a person in custody and the transfer from the police station to a prison was less than thirteen hours; the "24-hour rule" had not been respected in only nine cases.<sup>11</sup> At Oslo Police District Headquarters, the average time that elapsed between a person's arrival there and being transferred to a prison was approximately two days; normally, the appearance before the judge competent to order remand in custody occurred within 24 hours following arrest, and the transfer to a prison was made within 24 hours following the remand decision.<sup>12</sup> During the first half of 2005, the "24-hour rule" had not been respected in 73 cases.<sup>13</sup>

The CPT welcomes the efforts made by the Norwegian authorities to reduce the time of detention in police establishments for remand prisoners. **It must nonetheless emphasise that the objective should be to put an end, except in exceptional circumstances, to the practice of accommodating remand prisoners in police establishments.**

11. In accordance with the Immigration Act,<sup>14</sup> foreign nationals may be arrested and detained for identification, for a total period not to exceed - except on "special grounds" - twelve weeks, or in order to guarantee the execution of a decision to return them, for up to six weeks. If arrested, foreign nationals must be brought before the court with jurisdiction to order detention "as soon as possible, and as far as possible the day after arrest".<sup>15</sup> Arrest and detention are measures taken as a last resort; where they are ordered, the person concerned is normally sent to a holding centre for foreign nationals managed by the police (*utlendingsinternat*; cf. paragraphs 32 to 45).<sup>16</sup>

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<sup>8</sup> Act No. 21 of 18 May 2001 relating to the Execution of Sentences (Execution of Sentences Act, repealing the Prisons Act No. 7 of 12 December 1958).

<sup>9</sup> Section 4.1 of the Regulations of 22 February 2002 to the Execution of Sentences Act provides: "The Correctional Services shall without undue delay make prison accommodation available after a remand order is made. The Correctional Services and the police have a joint duty to ensure that such a transfer from police cells to prison is carried out.

In an especially exceptional case a person remanded in custody may be transferred from prison to a police cell in connection with the main hearing of a criminal case. This applies only if it is not possible to find a vacant place for custody on remand in the vicinity of the court..."

<sup>10</sup> In the whole of the country, the "24-hour rule" had not been observed 208 times during the first half of 2004, and 93 times during the same period in 2005.

<sup>11</sup> Maximum duration: two days (in one case).

<sup>12</sup> At the time of the delegation's visit, nine persons were being held at Oslo Police District Headquarters: seven had been there for less than ten hours; one for over 30 hours, waiting to be brought before the court; one for some 27 hours, having been remanded (some 20 hours after arrest) and returned to the police headquarters until a place in a prison became available.

Maximum duration: four days (in one case).

<sup>14</sup> Act No. 64 of 14 April 1988 concerning the entry of foreign nationals into the Kingdom of Norway and their presence in the realm (the Immigration Act).

<sup>15</sup> Sections 37, 37c and 41 of the Immigration Act.

<sup>16</sup> Section 37d *ibidem* (added by Act No. 22 of 30 April 1999, in force since 2003).

## 2. Ill-treatment

12. The great majority of the people met by the CPT delegation who were being held by the police - or who had recently been in police custody - said they had been properly treated, both when being apprehended and while being questioned. The small number of allegations of ill-treatment received chiefly concerned the excessive use of force at the time of apprehension, and abusive language.

This reasonably favourable state of affairs should not make the competent police and judicial authorities lose sight of the need to maintain suitable vigilance.

13. During the visit, the delegation was informed by the Norwegian authorities on the morning of 4 October 2005 that a person apprehended in Kristiansand early the previous evening had died during the night in the Central Police Station of that town.

On 6 January 2006, the Ministry of Justice and the Police sent the CPT the preliminary report drawn up on 5 December 2005 by the Special Investigation Unit (cf. paragraph 26), which had opened an inquiry on 4 October 2005. According to this document, it would not be possible to produce the final report until the final autopsy report had been received;<sup>17</sup> however, at that stage, in the light of the investigations carried out, there was no reason to suspect that a criminal act had been committed by the police officers concerned. **The CPT would like to receive, as soon as they are completed, copies of both the final report by the Special Investigation Unit and the final autopsy report.**

14. During the visit, the delegation received - from different sources - a number of complaints that it was not unusual for police officers to place handcuffs on the wrists or even ankles of persons having to be escorted from home to a psychiatric clinic, even where they put up no resistance. Such a practice, which criminalises and stigmatises patients, should cease. **The CPT would like to receive the comments of the Norwegian authorities on this matter.**

## 3. Safeguards against ill-treatment

15. In each of the reports on its periodic visits to Norway, the CPT has stressed the importance it attaches to the safeguards against ill-treatment which persons detained by the police must enjoy, and especially to these three fundamental rights: the right of detained persons to inform a close relative or another third party of their choice of their situation, to have access to a lawyer, and to have access to a doctor.<sup>18</sup> These rights must be secured for all categories of detainees, including persons detained pursuant to the aliens legislation, from the very outset of their deprivation of liberty. It is also essential that persons held by the police be informed of their rights without delay.

Respect for those fundamental safeguards is all the more important, considering that the first appearance before a magistrate may soon occur only three days after (and not, as is currently the case, on the day following) arrest (cf. paragraph 8).

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<sup>17</sup> The preliminary autopsy report had concluded that the cause of death could not be determined with certainty.

<sup>18</sup> Cf. CPT/Inf (94) 11, paragraph 29, and CPT/Inf (2000) 15, paragraph 19.

- a. notification of a close relative or third party

16. Regarding the right to inform a close relative or a third party of one's detention, Circular No. 5/2002 issued by the Director General of Public Prosecutions on 15 November 2002 has superseded - without amending them on this point - the provisional guidelines of 10 November 1999.<sup>19</sup> Thus, in accordance with paragraph VII.1.a of the Circular, persons suspected of a criminal offence are asked whether they wish their family or a third party of their choice to be informed of their arrest; if so, the information is communicated as soon as possible and usually not later than two hours after arrival at the police station.

However, it emerged from the delegation's interviews with persons deprived of their liberty that some of them had apparently not had the possibility of having a close relative or a third party notified. **The CPT recommends that the Norwegian authorities take the necessary steps to ensure the strict application of paragraph VII.1.a of the Circular in all police establishments.**

17. In their reply to the report on the visit made in 1999, the Norwegian authorities drew the Committee's attention to the safeguards attached to the possibility of deferring the exercise of this right, pursuant to Section 182 (2) CPA (risk of seriously prejudicing the investigation). In particular, when the decision not to inform a third party is taken, it must be recorded in a register, with a statement of the grounds.<sup>20</sup>

During its visit to Oslo Police District Headquarters, the CPT delegation was able to verify that this was the case. However, the Circular does not specify which authority is empowered to take the decision.<sup>21</sup> Moreover, consultation of the files has shown that the practice was to have no time restriction on the decision to defer notification, a state of affairs which will be of increased concern in the context of police custody of up to three days. **The CPT recommends that the Norwegian authorities revise the Circular in order to guarantee expressly that any decision to defer, as an exceptional measure, the exercise of the right to inform a close relative or a third party of one's detention, is subject to the approval of a senior police officer or a prosecutor and strictly limited in time.**

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<sup>19</sup> Cf. CPT/Inf (2000) 15, paragraph 21.

<sup>20</sup> Cf. CPT/Inf (2000) 16, page 9, and paragraph VII.1.b of the Circular.

<sup>21</sup> According to paragraph VII.1.b of the Circular, it is the responsibility of police chiefs to ensure that the appropriate procedures have been laid down. According to the Norwegian authorities, it implicitly follows from this text that the decision to defer the exercise of the right to inform a third party is in practice taken by a senior police officer or a public prosecutor (cf. CPT/Inf (2000) 16, page 9). During the 2005 visit, at Oslo Police District Headquarters, the decision to defer the exercise of this right was taken by the police lawyer in charge of the case file.

18. In its report on the visit made in 1999, the CPT recommended that the right to notify a close relative or a third party should be enjoyed by all persons deprived of their liberty by the police, including those apprehended under the Police Act.<sup>22</sup> Six years later, this recommendation had still not been fully implemented.<sup>23</sup>

**The CPT recalls its recommendation to the Norwegian authorities to take the necessary steps to ensure that all persons held by the police, irrespective of the reason for their apprehension, are expressly guaranteed the right to notify a close relative or a third party of their choice of their situation, from the very outset of their deprivation of liberty.**

b. access to a lawyer

19. In its report on the visit carried out in 1999, the CPT considered that the situation regarding the right of access to a lawyer was still not satisfactory, although it had undergone some positive developments after the adoption of new guidelines.<sup>24</sup>

At the time of the 2005 visit, the legal framework<sup>25</sup> governing this right remained unchanged; the above-mentioned Circular No. 5/2002 of 15 November 2002 had superseded the provisional guidelines of 10 November 1999 - while not amending them with regard to the right of access to a lawyer.<sup>26</sup> It was quite clear to the delegation from its interviews with persons in custody that, in practice, they did not all enjoy the right of access to a lawyer from the very outset of their deprivation of liberty. In fact, the situation varied greatly, ranging from prompt access to a lawyer (before any questioning took place) to a first contact with the lawyer only when brought before the magistrate competent to rule on the submission for remand in custody (in some cases more than 24 hours after arrival at the police station).

20. The CPT finds itself obliged to express its concern at this state of affairs. The Committee must recall once again that, in its experience, it is during the period immediately following the deprivation of liberty that the risk of ill-treatment, including intimidation, is greatest. Consequently, the right for persons taken into custody by the law enforcement authorities to have access to a lawyer during this period is a fundamental safeguard against ill-treatment.

The right of access to a lawyer must include the right for any detained person to talk to his lawyer in private as from the very outset of his deprivation of liberty. The person concerned should, in principle, be entitled to have a lawyer present during any interrogation, whether this be before or after he is charged. Naturally, the fact that a detained person has stated that he wishes to have access to a lawyer should not prevent the police from beginning to question him on urgent matters before the lawyer arrives. Provision could also be made for the replacement of a lawyer who impedes the proper conduct of an interrogation, on the understanding that such a possibility should be strictly circumscribed and subject to appropriate safeguards.

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<sup>22</sup> Cf. CPT/Inf (2000) 15, paragraph 23.

<sup>23</sup> Section 9-2 of the Police Instruction provides: "... Where the apprehended person is under 18, the parents or guardians shall be notified. In other cases, notification should be given to the family if there are special grounds."

<sup>24</sup> Cf. CPT/Inf (2000) 15, paragraphs 24 and 25.

<sup>25</sup> Cf. CPT/Inf (2000) 15, paragraph 25, and CPT/Inf (2000) 16, page 10.

<sup>26</sup> The delegation was informed that - following the amendment of Section 183 CPA - Section 98 CPA had been modified; under the new provision, not yet in force at the time of the visit, persons under arrest would be entitled to legal aid once it was established that they were to be deprived of their liberty for more than 24 hours.

The Committee further recognises that, in order to protect the interests of justice, it may exceptionally be necessary to delay for a certain period a detained person's access to a particular lawyer. However, this should not result in the right of access to a lawyer being totally denied during the period in question; in such cases, access to another lawyer should be arranged.

More than ten years after issuing recommendations on this matter for the first time, **the CPT calls upon the Norwegian authorities to ensure that the right of access to a lawyer, as defined above:**

- **is formally granted to everyone deprived of their liberty by the law enforcement authorities (including those apprehended under the Police Act) from the very outset of their deprivation of liberty, and**
- **is made fully effective in practice.**

c. access to a doctor

21. In July 2000, in reaction to recommendations issued by the CPT concerning access to a doctor, the Ministry of Justice and the Police sent police chiefs a circular (reference G-67/2000) in which, after pointing out that it was inappropriate for the police to screen detained persons' requests to have access to health-care services (since the necessity and nature of health-care should be determined by those qualified to do so, and since the role of the police should be to arrange contact between persons in their custody and the health services), it issued the following guidelines: all persons deprived of their liberty by the police (whatever the grounds for apprehension) were entitled to access to health-care services which should, in principle, include access to the doctor of their own choice; access may be arranged by telephone contact with health-care staff, detained persons being allowed to speak directly and without supervision to them if they so desired; access to health-care staff should be guaranteed as soon as possible, and, as a general rule, not later than two hours following the detained person's arrival at the police establishment (and after requesting care).<sup>27</sup>

22. It appears from the information gathered during the visit made in 2005 by the delegation to Oslo Police District Headquarters that the guidelines set out in the above-mentioned Circular were being correctly applied in that establishment. Thus, when a detained person asked to see a doctor, the latter was telephoned by the police, and the person concerned could speak directly over the telephone with the doctor, who, on the basis of this exchange, would decide whether or not to come and examine the person. In the event of a medical examination, a copy of the medical report was handed to the detained person and a copy was kept by the municipal medical service; the police did not receive a copy. However, the delegation received a few allegations that police officers had not acted upon requests for access to a doctor.

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<sup>27</sup> Cf. CPT/Inf (2000) 15, paragraph 27, and CPT/Inf (2000) 16, page 12.

23. The adoption of Circular G-67/2000 undoubtedly constitutes a positive development. Notwithstanding that current practice appeared to be in conformity with the principle of confidentiality, the CPT regrets that the opportunity of the adoption of the Circular was not taken to include an explicit and precise mention of the principle requiring any medical examination of a person in police custody to be conducted out of the hearing and - unless the doctor concerned expressly requests otherwise in a specific case - out of the sight of the police.<sup>28</sup> **It recommends that the Norwegian authorities remedy this deficiency.**

Moreover, **the CPT recommends that the Norwegian authorities take the necessary steps to ensure that the guidelines set out in Circular G-67/2000 are strictly applied in all police establishments.**

d. information on rights

24. Since the 1999 visit, an information booklet on the rights of detained persons has been published in fourteen languages. The CPT welcomes this development. However, during the 2005 visit it became apparent that the booklet was only given to persons arrested under the Criminal Procedure Act; furthermore, this was not done consistently. As a result, many detained persons met by the delegation said they had only been informed of their rights verbally - and then only partially. This state of affairs was confirmed by police officers who stated that "normally", when persons were placed in custody, they were informed of their rights verbally.

**The CPT recommends that the Norwegian authorities take the necessary steps to ensure that all persons detained by the police (including those apprehended under the Police Act) are informed in writing of their rights, at the very outset of their deprivation of liberty. Furthermore, the persons concerned should sign a statement attesting that they have been informed of their rights in a language which they understand.**

e. recording of police interviews

25. During the visit, the delegation was informed that a pilot project had been carried out from 1998 to 2003 in connection with the recording of police interviews and that, on the basis of the conclusions and recommendations delivered by the steering group of the project,<sup>29</sup> the police directorate had set up a working group responsible for the general introduction of sound and video recording of interviews in police departments. At the time of the visit, the working group was in the process of finalising its work.

The CPT is pleased to note these positive developments, which are in line with a recommendation made at the time of its first visit to Norway.<sup>30</sup> **It would like to be informed of the outcome of the working group's activities.**

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<sup>28</sup> In this respect, the Committee is of the opinion that Section 21 of the Health-Care Staff Act No. 64 of 2 July 1999, dealing with the obligation of confidentiality, is drafted in overly general terms (CPT/Inf (2000) 16, page 12).

<sup>29</sup> In particular, the steering group of this pilot project has concluded that there is benefit in sound recordings, and even video recordings in certain cases, of police interviews, and proposed that such recordings become a permanent and integral part of the investigation methods.

<sup>30</sup> Cf. CPT/Inf (94) 11, paragraph 40.

f. complaints procedures

26. Independent machinery for dealing with complaints lodged against the police is another significant guarantee for persons deprived of their liberty.

At the time of the 2005 visit, the Special Enquiry Boards (*Særskilt etterforskningsorgan* or SEFO)<sup>31</sup> were no longer functioning. They had been abolished because of the numerous criticisms made concerning their independence and replaced by a Special Investigation Unit (*Spesialenheten for politisaker*), set up on 1 January 2005.

The Special Investigation Unit's task is to deal with complaints involving criminal law laid against the police or the prosecution. It is based in Hamar and has five regional divisions covering the entire national territory.<sup>32</sup> The head of the Special Investigation Unit has the powers of a public prosecutor.<sup>33</sup> In particular, the decision to open an inquiry is taken by the head of the Special Investigation Unit. Following such a decision, investigations are conducted by the competent regional division which, at the end of the inquiry, forwards its report to the head. On the basis of this report, the latter can decide to dismiss the case or to charge the person or persons implicated; his decisions, issued in writing, state the grounds.<sup>34</sup>

The staff consists of fourteen permanent officers<sup>35</sup> and some twenty persons "associated with the Special Investigation Unit as members discharging official duties".<sup>36</sup> The latter are in principle appointed for four years; they must not have been employed by the police or the prosecution during the two years before taking up their special duties. Accordingly, members of the police force no longer take part in the inquiries. In this respect, however, the Norwegian authorities have reported that, in view of the need to recruit a large number of qualified and experienced people quickly at the start of 2005, a decision had to be made to accept applications from members of the police "on leave" from their posts in the police. The situation gradually improved and, by 2 November 2005, only three of the fourteen permanent members were police officers "on leave" from their posts in the police.

The CPT welcomes these developments, and **would like to know whether the Special Investigation Unit still has on its permanent staff persons "on leave" from their posts in the police.**

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<sup>31</sup> Cf. CPT/Inf (2000) 15, paragraph 30.

<sup>32</sup> Hamar (East), Haugesund (South), Bergen (West), Trondheim (Centre) and Bodø (North).

<sup>33</sup> Cf. Act No. 13 of 5 March 2004 and Sections 59-67 CPA.

<sup>34</sup> From 1 January to 10 October 2005, the Special Investigation Unit received 631 files (including 107 transferred from the SEFOs). A decision was given in 126 cases, in 88 of them without investigation (on the basis of the complaint and the relevant documents); 5 resulted in a decision to prosecute. The first hearings before the courts were scheduled for November 2005.

<sup>35</sup> The head of the Special Investigation Unit, three executive secretaries (assigned administrative tasks), a head of regional division (Hamar) and nine investigators.

<sup>36</sup> Approximately twenty legal specialists, and one psychologist.

#### 4. Conditions of detention

27. The Committee would like to recall the criteria it uses to evaluate conditions of detention in police establishments.

All police cells must be clean, of reasonable size considering the number of persons usually accommodated in them, adequately ventilated, and sufficiently well lit to allow reading outside the periods devoted to sleeping; cells should preferably receive natural light. In addition, they should be equipped in such a way as to allow rest (be equipped with a fixed seat or bench, for example), and persons obliged to spend the night in custody should have a mattress and clean blankets.

Persons detained by the police should be able to comply with the needs of nature when necessary, in clean and decent conditions, and be provided with adequate washing facilities. They should have access to drinking water and be given food at the appropriate times, including at least one full meal (i.e. something more substantial than a sandwich) every day. Persons held for extended periods (24 hours or more) should be provided with appropriate personal hygiene items and, as far as possible, be offered daily outdoor exercise.

28. Overall, the two police establishments visited in 2005 complied with the criteria set out above.

That said, the delegation observed that, notwithstanding Circular G-54/2000 adopted by the Ministry of Justice and the Police on 25 May 2000,<sup>37</sup> certain persons obliged to spend a night in a cell at Oslo Police District Headquarters had not received blankets.

Further, the delegation was informed that in this establishment the first meal was served after eight hours of detention. In this regard, many prisoners interviewed at Trondheim Prison complained that, during their detention in a police establishment, they had waited even longer (14, 17, even 24 hours) before receiving their first meal (sometimes just a sandwich).

29. **The CPT recommends that immediate steps be taken to ensure that:**

- **all persons obliged to stay overnight in a police establishment receive a mattress and clean blankets, without needing to ask;**
- **all persons held in a police establishment are given food at normal mealtimes, including a full meal (i.e. something more substantial than a sandwich) at least once a day.**

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<sup>37</sup> Cf. CPT/Inf (2000) 16, page 8.



30. At Trondheim police station, the delegation observed in some cells a metal ring fixed to the wall beside the bed (similar to those seen during the 1999 visit). In this regard, the CPT has taken note of the Norwegian authorities' observations to the effect that this apparatus, intended to restrain an aggressive person with the help of handcuffs, is only used in exceptional circumstances.<sup>38</sup>

The CPT must recall that it is inappropriate to restrain aggressive or agitated persons in such a fashion; in cases where a detained person is, or becomes, highly agitated or aggressive, the police should immediately contact a doctor and act in accordance with his instructions. Accordingly, **the CPT recommends that the metal rings in question, or any similar device, be removed.**

31. At the time of the visit, the delegation was informed of a number of building works, either in progress or planned, to renovate and improve police premises. In particular, police cells throughout the country were to be equipped with a video surveillance system.<sup>39</sup> In addition, a new wing was to be added to the Oslo Police District Headquarters buildings.<sup>40</sup> With regard to the increase in the maximum duration of police custody (72 hours), **the CPT would like to know whether the work being undertaken at Oslo Police District Headquarters includes an outdoor exercise area for detained persons.**

## 5. Trandum Aliens Holding Centre

### a. introduction

32. The holding centre for aliens at Trandum (hereinafter referred to as "the Centre") is a closed centre within the meaning of Section 37d of the Immigration Act (*utlendingsinternat*; cf. paragraph 11), administered by the Foreigners Unit of the National Police (*politietsutlendingsenhet*).<sup>41</sup> The Centre is also used as a place of temporary accommodation by foreign nationals who are not deprived of their liberty.

The Centre is situated near Gardemoen International Airport, away from any residential area. It is a former military barracks, renovated in the early 2000s and surrounded by a fenced area of land. With an official capacity of 200 places, the Centre accommodated 35 persons per day on average.<sup>42</sup> On the day of the delegation's visit, 42 persons were present.

The period of time spent at the Centre was generally short (averaging 2.5 days in 2004 and 3.3 days during the first eight months of 2005). The delegation nevertheless met persons who had been accommodated at the Centre for several weeks, and even for slightly more than a year in one case.

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<sup>38</sup> Cf. CPT/Inf (2000) 15, paragraph 18, and CPT/Inf (2000) 16, page 9. On its visit to Trondheim police station, the delegation was informed that the rings were not in use.

<sup>39</sup> The Ministry of Justice and the Police representatives whom the delegation met said that, despite the installation of a video surveillance system, inspections by staff (a patrol every 30 minutes) would continue.

<sup>40</sup> The delegation was informed that an earlier scheme to enlarge, renovate and improve the detention zone of the Oslo Police District Headquarters had been halted following intervention by the Parliamentary Ombudsman who considered that the planned new cells did not admit sufficient natural light.

<sup>41</sup> The Centre began to take in foreign nationals in 2001 after the closure of the Snarøya Aliens Detention Centre (cf. CPT/Inf (2000) 15, paragraphs 31 and 34); it had been managed by the Oslo police until 1 January 2004.

<sup>42</sup> With one notable exception: 99 persons awaiting transfer to Kosovo, on one day (autumn 2004).

b. material conditions and regime

33. The Centre consisted of four sections: the lower storey held one section for families and children and one "security" section<sup>43</sup> (cf. paragraphs 41 to 45), while the upper storey held a section for men and an unoccupied section. The male section and the section for families and children each had six bedrooms<sup>44</sup> measuring about 27m<sup>2</sup>. In the section for families and children, these bedrooms were of reasonable size considering the intended occupancy (in principle, four persons); however, in the male section, the bedrooms were designed to accommodate up to eight persons. This level of occupancy is rather high, even if detainees had access to a common room during the day. **The CPT invites the Norwegian authorities to reduce the occupancy rate in the bedrooms of the male section.**

The bedrooms were fitted with beds, which had clean mattresses and bedding. There were also lockable wardrobes, a table and chairs in the bedrooms for families and children; however, **these articles of furniture were absent from the men's bedrooms.** All the bedrooms, which were clean and well-kept, had satisfactory natural and artificial lighting; while ventilation was good in the bedrooms for families and children, it could be improved in the men's bedrooms. The sanitary facilities (two showers and two toilets per section), located in separate rooms, were generally acceptable.

34. Apart from the bedrooms, the male section and the section for families and children had a common room (with tables and chairs, a television set, some books, magazines and board games) and a sports room (containing in particular a table-tennis table and an exercise bicycle). In the male section, however, the sports room had not been accessible for three weeks. There was also a children's playroom in the section for families and children. Two outdoor yards had been fitted out, one with children's games equipment (in the section for families and children) and the other with a rain shelter and two basketball rings.

Detained persons could move about freely inside their section; only the doors to the sports rooms were locked. Access to these rooms and to the outdoor yards was allowed on request; it was refused or restricted when insufficient custodial staff were available. The persons held at the Centre with whom the delegation spoke said they went outdoors every day for periods of 30 minutes to two hours. **The CPT recommends that the Norwegian authorities take the necessary steps to ensure that all persons held at the Centre (including persons in the "security" section) are able to take at least one hour of outdoor exercise a day.**

35. In sum, conditions at the Centre could generally be considered satisfactory for short stays (of up to three or four days). However, as stated above, individuals might be held at the Centre for extended periods (of up to twelve weeks or more). **The CPT invites the Norwegian authorities to pursue their efforts to extend the activities offered to long-term detainees at the Centre. In this respect, measures should be taken (upkeep of equipment, presence of staff) to ensure regular access to the facilities already in existence, in particular the sports rooms.**

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<sup>43</sup> This section was unoccupied on the day of the visit.

<sup>44</sup> Temporarily, five bedrooms in the men's section, one having been fitted out as a prayer room during Ramadan.

c. staff

36. Apart from the head and the deputy head (both members of the Foreigners Unit of the National Police), the Centre's staff was composed of persons employed by the police and employees of a private security firm. On the day of the visit, five persons employed by the police and six employees of the security firm were present; several spoke English. The teams were always mixed (men and women).

The delegation was informed that the persons employed by the police had undergone four weeks of basic training during the summer of 2004, covering topics such as the legal framework (police, immigration), methods of apprehension, transport (overland and air), psychology, conflict management, stress endurance, ethics, cultural understanding and first aid.

The CPT welcomes the organisation of this training, which addresses a recommendation made after the 1999 visit.<sup>45</sup> **It would like to know whether the persons employed by the private security firm also receive appropriate training.**

d. medical care

37. Three doctors<sup>46</sup> attended the Centre in rotation, each being present on one afternoon per week (Mondays, Wednesdays and Fridays, for about two-and-a-half hours), and one of the doctors was always on call, in case of need. Specialist consultations, including dental treatment, were provided by outside specialists.

That said, the delegation was informed that, due to the long waiting periods for consultations with psychiatrists, persons requiring psychiatric treatment were usually cared for by the Centre's doctors. In this regard, the CPT must emphasise the need to pay very close attention to the mental health and the psychological condition of detained foreign nationals, as some may have gone through hardship - or even been subjected to torture or other forms of ill-treatment - in their countries of origin. **The CPT recommends that the Norwegian authorities take steps to ensure that the foreign nationals held at the Centre receive appropriate psychological and/or psychiatric services, preferably by having a psychologist and/or a psychiatrist regularly available for consultation at the Centre.**

38. The Centre's medical team did not include any nursing staff. Such a situation is unacceptable in an establishment that can accommodate up to 200 persons. Having regard to the average number of foreign nationals accommodated in the Centre, **the CPT recommends that at least one part-time nurse's post be created. The nursing staff could, for instance, conduct the initial medical interview of new arrivals (which should be systematic<sup>47</sup>), manage the medical records, assemble the requests for consultations (inside and outside the Centre), prepare medicines and ensure their distribution.**<sup>48</sup>

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<sup>45</sup> Cf. CPT/Inf (2000) 15, paragraph 33.

<sup>46</sup> Including a general practitioner and an anaesthetist.

<sup>47</sup> Cf. CPT/Inf (94) 11, paragraph 48.

<sup>48</sup> On the day of the visit, fifteen people were receiving medication (mainly sedatives for the night, painkillers and antibiotics); the medicines were distributed by custodial staff.

39. At the time of the visit, the delegation was informed that, in the context of deportation operations, the Centre's doctors examined the foreign nationals in question before the removal orders were executed, in order to fill in a certificate of fitness to travel ("fit to fly" certificate). These examinations, however, were not carried out systematically; they applied principally to pregnant women and to persons suffering from trauma or mental instability. A medical examination was also performed when a deportation operation was suspended; once again, this examination was not automatic, and normally took place only in the event of injury or attempted infliction of injury. It should be noted that the Instructions of 29 March 2005 issued by the chief of police (version No. 2) on the transport of foreign nationals did not contain any specific guidelines in this respect.

40. In its 13<sup>th</sup> General Report, the CPT stressed the importance that should be attached to medical examinations in the context of deportation operations.<sup>49</sup> The Committee of Ministers of the Council of Europe did likewise when adopting its Twenty Guidelines on Forced Return in 2005.<sup>50</sup> In the light of these texts, **the CPT recommends that the Norwegian authorities extend the practice of performing a medical examination before deportation to all deportation operations by air. Furthermore, all persons who have been the subject of an abortive deportation operation should undergo a medical examination as soon as they are returned to detention.**

**The CPT would also like to receive detailed information on the applicable regulations and practice as regards the administration of medicines to persons subject to a deportation order.**

e. "security" section

41. The "security" section consisted of three bedrooms, each measuring 27m<sup>2</sup> and furnished with four beds, a table and two benches, a room for activities (with a table-tennis table and an exercise bicycle) and a lounge (with television). There were also six individual cells, measuring almost 9m<sup>2</sup>, fitted with a bed, a table, a chair and a call system. All rooms were clean and well-kept, and had adequate artificial lighting and ventilation. In addition, access to natural light was acceptable in the six individual cells, and good in the other rooms.

The section also had two "bare" cells, each measuring about 7m<sup>2</sup> and equipped with only a mattress on the floor. The cells had no windows and were not equipped with a call system. In the CPT's opinion, **in their present state, these two cells are unsuitable for detention of any kind.**

42. Use of the "security" section was governed by written instructions from the chief of police and/or the head of the Centre.<sup>51</sup> According to these instructions, a foreign national could be placed in this section for a maximum of seven days, for example for putting up resistance while being transported to the Centre, for causing a disturbance inside the Centre, in the event of unsuccessful deportation, or for the purposes of an investigation.<sup>52</sup>

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<sup>49</sup> Cf. CPT/Inf (2003) 35, paragraph 39.

<sup>50</sup> CM(2005)40, 4 May 2005, Principle 16.

<sup>51</sup> Cf. in particular the Instructions of 23 September 2001, 25 May 2005 and 4 October 2005.

<sup>52</sup> Placement in the "security" section could also be effected at the request of the person concerned.

This section had four security levels. *Level 1* consisted of placement in a bedroom, with freedom to move around the section from 7 a.m. to 11 p.m. and permission to telephone one's lawyer or the police. *Level 2* entailed the same regime, but placement in an individual cell. *Level 3* involved placement in an individual cell, with permission to leave it "for exercise" (two hours per day) and to use the sanitary facilities, as well as permission, as far as possible, to telephone one's lawyer or the police; "if necessary", the detained person was handcuffed - and strips were used outside the cell. *Level 4* included placement in a "bare" cell, under constant visual surveillance by at least two custodial staff;<sup>53</sup> "if necessary", strips were applied and the walls padded with mattresses; the inmate was only allowed to leave the cell in order to use the sanitary facilities, with strips on wrists and ankles.

Placement in the "security" section, and the level of security, were decided by the duty officer who was required to notify his superiors immediately. This officer also had to indicate, "with a view to transfer to a more suitable establishment", whether "the resources needed to take care of the detainee" were available. The facts (incident prompting the placement decision, instructions, etc.) had to be recorded; there had to be an ongoing review, and documentary evidence, as to the necessity of maintaining the measure.

According to the indications given by one of the Centre's doctors, the doctors visited the "security" section at the request of the inmates - or of the custodial staff. Except in urgent cases, these visits were made on the routine consultation days (Mondays, Wednesdays or Fridays).

43. In accordance with the instructions in force, every placement in the "security" section had to be entered in a register. Furthermore, it was obligatory to fill in a sheet of instructions and a log of events/incidents in the case of placement in a "bare" cell or an individual cell. Consultation of the registers and the personal files did not, however, enable the delegation to gain a comprehensive idea as to how the "security" section was used. Indeed, very often the documents were incomplete (in particular, the grounds for placement were not specified), or missing altogether.

That said, on the basis of the information gathered, the two "bare" cells had been used ten times between 2 November and 23 December 2004, and nineteen times between 1 January and 8 May 2005. In most cases, the persons had apparently been placed in the cells for health reasons.<sup>54</sup> In general, they had been examined promptly by a doctor, and the checks by custodial staff were regular (but not constant). The duration of placement varied from a few hours to two or even three days.

As regards the individual cells, occupants were generally placed there for a period ranging from a few hours to three or four days when they were disruptive or before a deportation measure was carried out.

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<sup>53</sup> The delegation was informed that the cell's door remained open, with two members of the custodial staff sitting in the corridor facing the opening; these two staff members were relieved every 30 minutes.

<sup>54</sup> For example, transfer from hospital to the Centre or highly agitated while in the section.

44. The CPT recalls that it pays particular attention to detained persons who - for whatever reason (disruptive behaviour or "dangerousness", in the interest of a criminal investigation, or at their own request)<sup>55</sup> - are held under conditions resembling solitary confinement, and that a measure of this kind, whether enforced or voluntary, must be accompanied by a number of safeguards.

In particular, when isolation is imposed, the person concerned should as far as possible be informed of the grounds for the decision and its duration, and be allowed to express his views on the matter; he should also be able to address an authority independent of the one ordering it. Moreover, whenever a person placed in isolation (including cases where isolation is voluntary) asks for a doctor, one should be called forthwith to examine the person concerned; the findings of the medical examination, including an assessment of the person's physical and mental condition and, if necessary, the foreseeable consequences of being kept in isolation, should appear in a report to be transmitted to the competent authorities. Lastly, as already indicated (cf. paragraph 30), when a detainee is or becomes highly agitated or aggressive, the police should immediately contact a doctor and act according to his instructions.

**45. The CPT recommends that the instructions relating to the "security" section of the Centre be revised, in the light of the remarks made in paragraphs 34 and 44. It would, *inter alia*, be advisable for the instructions to distinguish clearly the different types of placement in use (voluntary or involuntary isolation, isolation for health reasons, isolation as a disciplinary measure) and the related procedures and guarantees; in particular, it would be unacceptable for a person placed in the "security" section to be denied access to his lawyer. These instructions - translated into an appropriate range of languages - should be at the disposal of the foreign nationals held at the Centre.**

**The CPT also recommends that a specific register be kept in the "security" section, containing information on the identity of the person placed in isolation, grounds for the measure, date and time the measure began and ended, means of restraint (if used), the authority which took the decision, and the precise location where the detainee was placed.**

In addition, the CPT would like to receive detailed information on the policy and practice regarding the use of wrist and ankle strips inside the "security" section (protocol/instructions, as well as statistics for 2005).

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<sup>55</sup> Cf. CPT/Inf (94) 11, paragraph 57.

## **B. Prisons**

### **1. Preliminary remarks**

46. During the 2005 visit, the CPT carried out a follow-up visit to Ila Prison;<sup>56</sup> it also visited Ringerike and Trondheim Prisons for the first time.

The Ila Prison for Preventive and Security Detention is the only prison in Norway with the specific purpose of receiving male prisoners who have been sentenced to serve a period of preventive detention (Sections 39c to 39h of the Penal Code).<sup>57</sup> On the first day of the visit, the prison, with an official capacity of 110 places, was accommodating 108 prisoners, 56 in preventive detention, 35 sentenced, and 12 in remand.<sup>58</sup>

Ringerike Prison, which came into operation in 1997, is located in the vicinity of Hønefoss. Since 1999, when it was decided to create a very high security unit (Section 6.1 of the Regulations to the Execution of Sentences Act), this establishment - for male prisoners only - is the country's highest-security prison. With an official capacity of 160 places, it was accommodating 155 prisoners on the first day of the visit (107 convicted, 46 in remand and two imprisoned for failure to pay fines).

Trondheim Prison, built in 1971, is located in the city suburbs. It has an official capacity of 144 places. There were 135 inmates, including 103 sentenced prisoners, of whom 6 were women, 30 remand prisoners, and two persons in preventive detention (Section 39c of the Penal Code).

47. Since the CPT's visit in 1999, the legislation has undergone a number of reforms. In particular, besides the adoption of the provisions on preventive detention,<sup>59</sup> a new Act on the Execution of Sentences came into force in 2002.<sup>60</sup> Furthermore, the Criminal Procedure Act has been amended, mainly with a view to strengthening the role of the judicial authorities when remand prisoners are placed in solitary confinement.<sup>61</sup>

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<sup>56</sup> Cf. CPT/Inf (94) 11, pages 25 to 47.

<sup>57</sup> Section 39c of the Penal Code, which introduced a new penalty (preventive detention in a prison), came into force on 1 January 2002. Under the terms of this provision, the court may order a person who has committed or attempted to commit certain serious offences (in particular, offences against life and physical integrity) to be placed in custody in a prison for an indeterminate period of time when the risk of reoffending seems imminent and when custody is considered necessary to protect society. Section 39g of the Penal Code provides that the court shall fix a minimum period (not exceeding ten years) and a maximum period (normally not exceeding fifteen years and in no circumstances exceeding twenty-one years); three months before the period of custody expires, the public prosecutor may nevertheless request a five-year extension, which is renewable.

In exceptional cases, prisoners ordered to be placed in preventive detention were held in other establishments than Ila Prison. Women held under these provisions were detained at Bredtveit Prison for Preventive and Security Detention.

<sup>58</sup> There were also five persons held under the earlier legislation (cf. CPT/Inf (94) 11, paragraph 54 (security detention)).

<sup>59</sup> Sections 39c to 39h of the Penal Code, as well as implementing Regulation No. 481 of 5 March 2004.

<sup>60</sup> Act No. 21 of 18 May 2001 relating to the Execution of Sentences (Execution of Sentences Act), and Regulations of 22 February 2002 to the Execution of Sentences Act, in force since 1 March 2002.

<sup>61</sup> Cf. Section 186 CPA (amended) and Section 186a CPA (new), in force since 1 October 2002.

## 2. Ill-treatment

48. As during the 1999 visit, the delegation received no allegations and found no other signs of ill-treatment by staff in the establishments visited or in other prisons in Norway. In general, relations between staff and prisoners were relaxed; at Ila Prison in particular, they seemed to be constructive, and many prisoners met by the delegation spoke favourably of the staff.

49. The CPT's mandate is not confined to preventing ill-treatment inflicted by members of staff. While the CPT pays particular attention to such conduct, it is also concerned when it discovers an environment which is conducive to inter-prisoner intimidation and violence.

At Trondheim Prison, the delegation received from prisoners with whom it spoke a few allegations concerning acts of inter-prisoner violence, including violence in the form of physical assault (blows). In one case, the allegations were confirmed by the data contained in the prisoner's medical record.<sup>62</sup>

50. The CPT would like to emphasise that the duty of care which is owed by the prison authorities to prisoners in their charge includes the responsibility to protect them from other inmates who might wish to cause them harm.<sup>63</sup> Any strategy aimed at solving the problem of inter-prisoner intimidation or violence, if it is to be effective, should seek to ensure that prison staff are placed in a position to exercise their authority in an appropriate manner. Consequently, the levels of staffing must be sufficient (including at night-time); furthermore, staff must be alert to signs of trouble, and be both resolved and properly trained to intervene when necessary.

Another important means of preventing inter-prisoner violence lies in the prison administration's diligence in examining all relevant information concerning the allegations of inter-prisoner violence brought to its attention, and in taking steps where necessary. The lack of an appropriate reaction by the prison administration can foster a climate in which inmates inclined to ill-treat other inmates can quickly come to believe - with very good reason - that they can do so with impunity. Prison doctors - as well as nursing staff - also have an important role to play in this context, in so far as they are often the first to be in contact with prisoners who have suffered ill-treatment or received threats from fellow inmates.

**The CPT would like to receive detailed information on the extent of inter-prisoner violence in Norwegian prisons, and specifically at Trondheim Prison, as well as on the strategies applied to address this phenomenon.**

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<sup>62</sup> This case concerned a prisoner suspected of having committed a sexual offence who claimed to have been beaten (punched and kicked on various parts of the body) by three fellow prisoners one day after his admission to the establishment on 24 September 2005; the report of the emergency doctor who examined him contained the following indications: "haematoma and swelling of ear; eardrum ruptured; possible rib fracture".

<sup>63</sup> Cf. 11<sup>th</sup> General Report, CPT/Inf (2001) 16, paragraph 27.



### 3. Court-ordered solitary confinement of remand prisoners and other restrictions

51. Since the CPT's first visit to Norway in 1993, the issues relating to solitary confinement of persons held on remand, and to the other restrictions placed on them in the interests of the investigation, have had a consistently high profile in the ongoing dialogue between the CPT and the Norwegian authorities.

52. As stated above (cf. paragraph 47), since the 1999 visit several changes with regard to these matters have been introduced in the legal framework.

Under the terms of the Criminal Procedure Act, the solitary confinement of a person remanded in custody must henceforth be ordered by a judicial authority.<sup>64</sup> Furthermore, the grounds for the judicial authority's decision must be given.<sup>65</sup> Where complete solitary confinement is ordered, the initial duration thereof cannot exceed two weeks, renewable in successive instalments of two or four weeks, and its total duration must not in principle exceed three months.<sup>66</sup> However, according to Section 186a CPA, "if strong considerations make it necessary", a remand prisoner may be kept in complete solitary confinement for longer than three months.

**In the CPT's opinion, the Criminal Procedure Act should stipulate an absolute upper limit on the duration of solitary confinement of remand prisoners by court order.**

53. On 15 November 2002, following the entry into force of these legislative amendments, the Director General of Public Prosecutions issued a Circular (No. 5/2002) concerning, in particular, solitary confinement and other restrictions.

As regards these issues, although the Circular supersedes the guidelines issued by the Director General of Public Prosecutions on 10 November 1999, it also confirms them in many respects. For example, the prosecution authorities must only apply for restrictions when this is necessary for the investigation - and never for the purpose of bringing pressure to bear on persons remanded in custody; they must not apply for, or maintain, more extensive restrictions than are strictly necessary; and they must state the grounds for applying for restrictions.<sup>67</sup> It is also emphasised that complete solitary confinement - "an extremely invasive measure" - must be applied with great caution. According to the Circular, the duration of the restrictions must be "as short as possible"; in this respect, it is specified that the police lawyer must continuously assess the need to maintain the restrictions, and that they must be lifted as soon as there is no longer any risk of evidence being interfered with.

**The CPT recommends that, during each periodic review by the court of the necessity to maintain remand in custody, there should be a reconsideration of whether the restrictions imposed upon a remand prisoner should be maintained.**

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<sup>64</sup> Sections 186 (partial solitary confinement) and 186a (complete solitary confinement) CPA.

<sup>65</sup> Sections 186 (3) and 186a (5) CPA. The court ruling must indicate in what way the non-imposition of restrictions/solitary confinement would prejudice the investigation; it must also be apparent from the wording of the decision that the restrictions/confinement are not disproportionate measures.

<sup>66</sup> Section 186a CPA; where the remand prisoner is under 18 years of age, the term of complete solitary confinement may in no circumstances exceed eight weeks.

<sup>67</sup> Cf. CPT/Inf (2000) 15, paragraphs 42-45.

54. In response to a recommendation made by the CPT, the Norwegian authorities have carried out a study on the implementation of the guidelines of 10 November 1999. According to the results of the study, which dealt with the restrictions requested/imposed during the first half of 2002, the aforementioned guidelines were, in general, satisfactorily applied. However, the obligation to state grounds for restrictions was problematic in that only 17% of requests were properly justified and 53% contained no indication regarding the necessity of the restrictions requested.<sup>68</sup>

At the time of the 2005 visit, a few remand prisoners complained to the delegation that police officers had applied or threatened to apply restrictions (concerning visits and telephone contacts in particular) in order to extract certain statements from them.

**The CPT recommends that the Norwegian authorities ensure the strict application of Circular No. 5/2002 issued by the Director General of Public Prosecutions on 15 November 2002. It would be particularly advisable to issue a firm reminder to the prosecutors and members of the police concerned that it is inadmissible to apply or to maintain restrictions for the purpose of pressuring a person remanded in custody to co-operate in the police investigation.**

55. In its report on the 1999 visit, the CPT recommended that the Norwegian authorities pursue their efforts to offer additional activities and appropriate human contact to remand prisoners held under restrictions.<sup>69</sup> Since then, a number of legislative and regulatory amendments have come into force and some projects<sup>70</sup> have been initiated in line with the recommendation. For instance, under the terms of the Execution of Sentences Act and its implementing regulations, the Prisons Department shall give priority to measures remedying the ill-effects of solitary confinement of remand prisoners under restrictions imposed pursuant to Section 186 (2) CPA, and persons on remand and other prisoners placed in solitary confinement shall be given priority for participation in activities and contact with staff.<sup>71</sup> During the 2005 visit, the Norwegian authorities also informed the delegation that, since 1999, the application of restrictions on persons remanded in custody had been reduced, as had the duration of solitary confinement which - where ordered - seldom exceeded four weeks. The CPT welcomes these first steps in the right direction.

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<sup>68</sup> This state of affairs prompted the Director General of Public Prosecutions to remind prosecutors that it was their duty to justify, by stating special grounds, requests for the imposition of restrictions; it would not suffice merely to invoke the grounds supporting the application for remand in custody, or the "interests of the investigation" (cf. Restrictions in relation to remand in custody, publication of the Director General of Public Prosecutions No. 1/2003, September 2003).

<sup>69</sup> Cf. CPT/Inf (2000) 15, paragraph 47.

<sup>70</sup> For example, the formation of the working group "Quality in Remand Practice" (*Kvalitet i varetektsarbeidet*) at Oslo Prison.

<sup>71</sup> Section 46 (2) of the Execution of Sentences Act, and Section 1 (2) of the implementing regulations thereto.

56. Even so, in Norway almost 35% of persons remanded in custody during the first half of 2005 had been placed under restrictions by court order; nearly half of these restrictions included at least one measure of solitary confinement (complete or partial).<sup>72</sup> At the time of the visit, the delegation again met remand prisoners placed in complete or partial solitary confinement by court order, being locked in their cells for 22 or 23 hours per day and having little human contact inside the prison (whether with staff or other inmates), sometimes for several weeks or even several months. In addition, confinement was often associated with restrictions on visits, correspondence, reading newspapers, listening to the radio and/or watching television.

In the light of the above, **the CPT recommends that the Norwegian authorities pursue their efforts to provide activities and appropriate human contact for remand prisoners held in solitary confinement and/or under restrictions.**

#### 4. Conditions of detention

##### a. material conditions

57. In the main, the description of Ila Prison in the report on the CPT's 1993 visit is still valid.<sup>73</sup> Since that time, major renovation work has nevertheless been carried out and the delegation was informed that additional work was planned. At the time of the 2005 visit, building A had six sections: four for persons in preventive detention (A to D), and two for convicted prisoners (E and F), and building B, five sections: one for remand prisoners (G), one for convicted prisoners (H), two for persons in preventive detention (I and L), and one which was not being used (K). The capacity and use of the annex had remained unchanged.<sup>74</sup> At Ringerike Prison, the inmates were accommodated in four separate buildings: A (29 places, including the very high security unit, five places), B (49 places), C (49 places) and D (28 places). At Trondheim Prison, the inmates were accommodated in three wings: A (remand prisoners, detainees awaiting transfer to a psychiatric hospital, and female prisoners), B and C (principally convicted prisoners); there was also a separate prefabricated building for fifteen prisoners, a so-called "contract unit" for drug abuse treatment.

58. In the three prisons visited, material conditions of detention were generally of a high standard. Prisoners were accommodated in individual cells of satisfactory size (approximately 6.50m<sup>2</sup> to 12m<sup>2</sup>), with good natural lighting and equipped with adequate artificial lighting and ventilation. The cells were suitably furnished (a bed, a table, a chair, a wardrobe and shelves); many prisoners had a radio and/or television set, and even a computer. At Ringerike Prison, all cells had a fully equipped sanitary annexe (WC and shower). At Ila Prison, some cells only had a washbasin; however, the delegation received no complaints about night-time access to the lavatory. The situation was not as favourable at Trondheim Prison. The cells in the women's unit did not have their own toilet facilities and, because of the limited number of custodial staff present at night (cf. paragraph 70), inmates did not have access to the lavatory. Consequently, at night they had to use a chamber pot, emptied each morning.

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<sup>72</sup> During the first half of 2005, of the 1,533 persons remanded in custody in Norway, 548 had restrictions imposed on them by a court, 205 of the latter being placed in complete solitary confinement (possibly with other restrictions) and 21 of them being placed in partial solitary confinement (possibly with other restrictions).

<sup>73</sup> Cf. CPT/Inf (94) 11, paragraph 54.

<sup>74</sup> Cf. CPT/Inf (94) 11, paragraphs 54 and 84: 12 places, for prisoners who have trouble fitting in.

59. Ready access to proper toilet facilities and the maintenance of good standards of hygiene are essential components of a humane environment. In this connection, the CPT deplores the practice found in certain countries of prisoners discharging human waste into buckets in their cells (which are subsequently "slopped out" at appointed times). Either a toilet facility should be located in the cells (preferably in a sanitary annex) or means should exist which enable prisoners who need to use a toilet facility to be released from their cells without undue delay at all times (including at night). **The CPT recommends that immediate steps be taken to ensure that female inmates at Trondheim Prison enjoy unrestricted access to the lavatory at all times, day or night; ideally, they should have the use of in-cell toilet facilities which are partitioned off.**

60. The common areas (kitchens, lounges, activity rooms) were generally well-equipped, clean and well-kept. However, **the sports room in the women's unit at Trondheim Prison had no ventilation system.**

As regards the open-air exercise yards at Ila and Trondheim Prisons, these call for no particular comment. At Ringerike Prison, however, the very high security unit had four outdoor exercise areas, three of which were surrounded by walls on two sides and by grilles on the other two sides and overhead, making them cage-like. Further, these were not spacious enough to allow prisoners to exert themselves physically. **The CPT has misgivings about such facilities.**

b. regime

61. The regimes offered at Ila Prison were, as at the time of the 1993 visit,<sup>75</sup> generally satisfactory.

62. At Ringerike Prison, the regime for the prisoners held in *building A* (normally new arrivals and prisoners subject to restrictions or placed in solitary confinement) was particularly bleak. In fact, these prisoners generally had one hour of outdoor exercise per day, alone or in small groups, and 40 minutes of physical activity in a sports room once or twice weekly, alone. Besides this, they could spend time with other inmates in the corridor of their section during the distribution of lunch. What little prison work existed was monotonous and uninteresting.<sup>76</sup> In short, most prisoners in building A remained locked in their cells for more than 22 hours per day; their main pastimes were watching television, listening to the radio or reading.

Such a restrictive regime was especially hard to accept for prisoners compelled to remain in building A for the sole reason that the prison's other buildings were full. For instance, the delegation met a prisoner who, after having been placed in solitary confinement for a specified term in building A under Section 37 of the Execution of Sentences Act (exclusion from company), subsequently had to wait 77 days before he could be transferred to another building. Furthermore, some prisoners complained that at times they had been denied access to the sports room because insufficient custodial staff were present.

The situation was better in *buildings B, C and D*, where many prisoners spent a good part of the day working or following vocational training or educational activities<sup>77</sup> in very well-equipped workshops and classrooms. Recreational activities (reading, music, sport) were also offered.

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<sup>75</sup> Cf. CPT/Inf (94) 11, paragraph 84.

<sup>76</sup> At the time of the 2005 visit, three prisoners were in charge of cleaning and one worked in the assembly shop.

<sup>77</sup> Carpentry workshop in building B; mechanical workshop in building C; school in building D.

63. The regime offered to prisoners considered to pose particular risks<sup>78</sup> and placed in the *very high security unit* was extremely limited. The three prisoners being held in this unit at the time of the visit rarely spent more than two hours per day outside their cells: this included one hour of outdoor exercise in an austere yard (cf. paragraph 60) and the rest of the time within the unit, with access to a communal room (equipped with a TV and a computer) and a gym. Contact with other detainees - if this was not restricted by the judicial or prison authorities - was in principle only possible with fellow inmates from the same unit. However, once a week, they were visited by the head nurse, the prison chaplain, and the activities manager. At regular intervals (every two or three weeks), the detainees concerned had to change cells.

The delegation met detainees who had been subjected to such a regime for very long periods (and for some of whom, the regime was still ongoing). By way of example, a detainee had been placed in the very high security unit for nearly two years (October 2001 to August 2003) and with a total isolation regime for almost the entire period. Another detainee had been placed in the very high security unit from October 2004 to September 2005 by the prison authorities,<sup>79</sup> after a period of total isolation imposed by the judicial authorities following his arrest in May 2004.

64. Once more, observations made by the delegation's psychiatrists in the establishments visited tend to confirm that prolonged periods of isolation without appropriate mental or physical stimulation can have detrimental consequences on the prisoners' mental state. The symptoms observed ranged from mental confusion to suicidal thoughts; they were frequently accompanied by sleeping problems and somatic reactions.

65. At Trondheim Prison, the regime for sentenced prisoners was of a good standard; most of them worked (carpentry, mechanical and painting workshops, etc.) or were studying. The situation was much less favourable for remand prisoners (2/3 of whom were not participating in any activities) and for women, who were spending the day idly in the communal area of their unit.

66. The CPT is aware that the organisation of regime activities for remand prisoners is not a straightforward matter. Clearly, there can be no question of individualised treatment programmes of the kind which might be aspired to for sentenced prisoners. However, prisoners cannot simply be left to languish for weeks, possibly months, locked up in their cells, and this regardless of how good material conditions might be within the cells. The CPT considers that the aim should be to ensure that all prisoners are able to spend a reasonable part of the day (8 hours or more) outside their cells, engaged in purposeful activities of a varied nature. Regimes for sentenced prisoners should of course be even more favourable. It is also essential that women have access to purposeful activities on an equal footing with their male counterparts.

**The CPT recommends that measures be taken at Ringerike and Trondheim Prisons, ensuring that all prisoners (sentenced or on remand, male or female) spend a reasonable part of the day outside their cells, engaged in purposeful activities of a varied nature.**

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<sup>78</sup> By way of example, special risk of escape or risk of hostage taking (cf. section 6 (2) of the Regulations to the Execution of Sentences Act).

<sup>79</sup> Cf. Section 37 of the Execution of Sentences Act.

67. Further, the CPT is of the opinion that the Norwegian authorities could and should do more to attenuate the deleterious effects of isolation applied at the very high security unit of Ringerike Prison (whichever authority ordered it or whatever the reason behind this decision). The existence of a satisfactory programme of activities is just as important, if not more so, in a high security unit as in an ordinary unit. Indeed, such a programme can do much to counteract the detrimental effects on the prisoners' personality or life in the confined environment of such a unit. **The CPT recommends that the programme of activities at the very high security unit of Ringerike Prison be reviewed, in the light of the above comments and the principles set out by the CPT in this area (cf. 11<sup>th</sup> General report, CPT/Inf (2001) 16, paragraph 32).**

68. As already indicated (cf. paragraph 3), the delegation went to Stavanger Prison with a view to meeting twelve remand prisoners subject to special security measures. The establishment had been almost entirely emptied of its prisoners on the occasion of the trial in this town of these twelve persons.<sup>80</sup> The special security measures included, *inter alia*, a full strip-search before departure for and return from court; the systematic changing of cell accommodation on return from court; the wearing of both hand- and ankle-cuffs during transportation to and from court. It appears from the observations made by the delegation that the accumulation of very long periods of isolation and the restrictions previously applied,<sup>81</sup> together with the special security measures described above, had had a highly adverse effect on the physical and mental health of several of the prisoners. Given these circumstances, the delegation was concerned to hear repeated allegations that access to medical and psychological/psychiatric care had been delayed or, on occasion, denied. **The CPT would like to receive the comments of the Norwegian authorities on this issue, as well as detailed information on the legal basis for such special security measures.**

## 5. Staffing issues

69. None of the establishments visited were understaffed; however, the delegation was informed that the level of absenteeism among custodial staff was approximately 40% at Ringerike Prison and around 16% at Trondheim Prison. In the CPT's experience, such a state of affairs can be an indication of a more profound malaise, the reasons for which should be identified and tackled. **The CPT recommends that the Norwegian authorities carry out a survey on the phenomenon of absenteeism among custodial staff at Ringerike and Trondheim Prisons (and, if deemed necessary, throughout the whole prison system).**

Furthermore, **it would like to receive a copy of this survey when available.**

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<sup>80</sup> As a result, the twelve remand prisoners were accommodated in empty wings.

<sup>81</sup> At the time of the 2005 visit, none of the twelve remand prisoners was held in complete isolation ; those (six) who had not yet been questioned by the court were held in partial isolation. However, many of them had been previously held (at Stavanger Prison or other prisons) in complete isolation for prolonged periods and under more or less severe restrictions concerning contact with the outside world (telephones calls and visits; access to newspapers, radio, television) ordered by the courts (under the Criminal Procedure Act) and the prison authorities (under the Execution of Sentences Act).

70. Low staff cover at night was also of particular concern to the delegation. By way of example, only six members of staff were present at Trondheim Prison at night, and eight at Ila Prison. Such a state of affairs had a direct impact on the detainees' quality of life (cf. paragraph 58). Moreover, it can have serious consequences for the overall security of the prisons (i.e. prevention of escape or fire) and the personal security of both staff and inmates.<sup>82</sup> **The CPT invites the Norwegian authorities to reconsider the minimum level of staffing at night in the prisons visited.**

## 6. Medical services

71. As regards somatic care, the medical team at Ila Prison was composed of a post shared by three medical doctors (three days a week), a part-time physiotherapist (80%) and six full-time nurses (several of them with psychiatric expertise). At Ringerike Prison, the medical team was composed of three medical doctors sharing a part-time post (40%), a full-time physiotherapist and four nurses (sharing 3.4 posts), including one psychiatric nurse. A medical doctor visited Trondheim Prison twice a week (for a total of twelve hours), as did a physiotherapist (on a half post) and five nurses (sharing 2.4 posts), including a psychiatric nurse on a half post. Outside working hours, the emergency services of the local hospitals were contactable at any time.

72. The medical team at Ila Prison was sufficiently staffed; however, this was not the case at Ringerike and Trondheim Prisons. In the CPT's view, **both establishments - accommodating between 140 and 160 prisoners - should each benefit from a half-time medical doctor's post.**

Further, **the nursing team at Trondheim Prison should be reinforced to the level of three full-time nursing posts.** An increase in nursing posts and a better distribution of the nursing presence during the day should also ensure that - at least on weekdays - distribution of medication would be carried out by medically trained staff.

73. The importance of proper medical screening of newly arrived prisoners cannot be overemphasised, particularly in establishments which constitute points of entry into the prison system. Such screening is essential, particularly to prevent the spread of transmissible diseases, to prevent suicides, to identify prisoners with drug-related problems and to record injuries in good time.

At Ila and Ringerike Prisons, prisoners were examined by a nurse on the day of or the day after their arrival at the establishment, and one to two weeks later by a doctor, depending on the need. At Trondheim Prison, the medical examination on admission was also carried out by a nurse, who referred the prisoner to the doctor if needed. However, such an examination took place, at the very best, a few days after the prisoner's arrival at the establishment. In some - rare - cases, it appears that no initial medical examination was carried out at all.

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<sup>82</sup> By way of example, at Trondheim Prison the delegation was informed that every intervention at night, in particular in the "security cells area" (cf. paragraph 84), represented a considerable challenge for the staff.

**The CPT recommends that immediate steps be taken at all three establishments visited to ensure that every newly-admitted prisoner - whether sentenced or on remand - is properly interviewed and physically examined by a medical doctor as soon as possible after admission; save in exceptional circumstances, the interview/examination should be carried out on the day of admission. Such medical screening could also be performed by a fully qualified nurse reporting to a doctor; however, this should not unduly delay the interview with the doctor.**

74. As regards psychological and psychiatric care, Ila Prison benefited from the services of a psychiatrist one day a week, and of three part-time psychologists. Consequently, the waiting time for a consultation with the psychiatrist or a psychologist was usually at least a "few weeks"; this situation gives all the more cause for concern as the delegation observed amongst prisoners, and particularly amongst the prisoners sentenced to a period of preventive detention, significant psychological stress due to the uncertainties concerning the length of their sentences.

Ringerike Prison was visited every week by two psychiatrists, for four hours each. At Trondheim Prison, no such consultations were held; however, prisoners suffering from acute psychiatric symptoms were sent to Brøset Psychiatric Hospital. Further, two psychologists were holding weekly consultations at the prison. Consequently, nurses were obliged to filter the prisoners' requests to see a psychologist.

75. Given the high proportion of mental health problems among prisoners - particularly among prisoners in isolation or subject to restrictions - and the prevalence of behaviour related to drug addiction - such a state of affairs is far from satisfactory.

In addition, the delegation formed the impression that many inmates with mental health problems at Trondheim Prison, and to some extent at Ringerike Prison, were dealt with superficially, due to the shortage of psychiatrists. Moreover, at Trondheim Prison, inmates with mental disorders were occasionally restrained (cf. paragraph 84) without proper medical indication or monitoring.

**The CPT recommends that the provision of psychological/psychiatric services at the establishments visited be substantially increased in the light of the above comments. In particular, immediate measures should be taken to ensure regular visits by a psychiatrist to Trondheim Prison.**

76. As was the case during the 1993 visit, the delegation met a certain number of mentally ill prisoners at Ila Prison. The doctors were clearly trying to transfer them to a psychiatric establishment.<sup>83</sup> However, such transfers were difficult, due to the apparent shortage of hospital beds. Further, their return to the prison was sometimes premature, taking place when the patients' mental state was not yet stabilised.

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<sup>83</sup> Certain cases had been brought to the attention of the Ministry of Justice.



The CPT would like to recall that prisoners suffering from a mental illness should be cared for and treated in an adequately equipped and staffed hospital establishment. The rapid transfer of these prisoners to a psychiatric unit allowing them to receive appropriate care should be given a very high priority.<sup>84</sup>

**The CPT recommends that the Norwegian authorities take steps to ensure that prisoners suffering from a mental illness are transferred when necessary to an appropriate hospital establishment.**

77. At Trondheim Prison, foreign prisoners expressed their frustration at the difficulties encountered in communicating with health-care staff (due to the complex medical terminology and associated language barriers). In practice, they would indicate with gestures to the doctor the aching part of their bodies, hoping that their health problem would be understood. Such a situation may jeopardise the health of these prisoners. **The CPT recommends that whenever members of the medical and/or nursing staff are unable to make a proper diagnosis due to language problems, the services of a qualified interpreter be made available without delay.**

Further, the delegation received complaints from foreign prisoners indicating that they had to request special prison leave to obtain access to outpatient specialised care. **The CPT would like to receive the comments of the Norwegian authorities on this issue.**

78. At Ringerike Prison, a prisoner held at the very high security unit complained to the delegation that he had been examined by the doctor in the presence of two prison officers, despite the express request by the doctor that the examination take place in private. The CPT would like to stress that the principle of confidentiality requires that all medical examinations of prisoners (whether on arrival or at a later stage) be conducted out of the hearing and - unless the doctor concerned requests otherwise in a particular case - out of the sight of prison officers. **The CPT recommends that measures be taken to guarantee that this is indeed the case.**

79. The delegation was informed of the case of a female Norwegian prisoner who died on 8 September 2005 at St Olavs Hospital, two days after having been transferred there from Trondheim Prison. It would appear that, having abused illicit substances for a number of years, this prisoner experienced serious withdrawal symptoms. However, the first autopsy report was apparently inconclusive and a second autopsy was requested by the authorities. **The CPT would like to receive a copy of this second autopsy report in due course.**

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<sup>84</sup> Cf. CPT/Inf (94) 11, paragraph 94.

## 7. Means of restraint/isolation

80. Section 38 of the Execution of Sentences Act provides for the use of different means of restraint - such as security cells or restraining beds - in certain circumstances, for example agitation and self-harm. Such measures may only be used if they are strictly necessary and if lesser measures appear to be inadequate; however, the law does not provide for a maximum duration for the use of restraints. In principle, the use of restraints is decided by the Governor of the establishment or a member of staff acting on his behalf and, after a certain period of time, by the prison authorities at regional or national level. "As far as possible, a medical opinion should be obtained and taken into account in considering whether a decision should be made to use a security cell or a restraining bed", and an entry in the logbook should be made without delay.<sup>85</sup>

81. The security cells at Ila Prison - including one equipped with a restraining bed - have already been described in the 1993 visit report<sup>86</sup> and do not call for further comment.

Ringerike Prison had three security cells - including one with a restraining bed - located in building A. Measuring some 8.5m<sup>2</sup>, they were equipped with a bed/mattress, a small window and a floor toilet. There was a call system in all cells and a CCTV monitoring system<sup>87</sup> in the cell containing the restraining bed.

Trondheim Prison had three security cells, all located on C Wing. They were mainly used to restrain agitated inmates. Further, one cell was equipped with a restraining bed, used for the most serious cases of agitation. The above cells were only equipped with a bed/mattress and a floor toilet. Access to natural light in the cells was, at best, mediocre.

82. Registers examined at Ila Prison showed that, between 1 January and 29 September 2005, security cells had been used on seven occasions and the restraining bed on three. Prison officers had to complete a form including information on three areas: reason for the measure, alternative (lesser) measure, notification to medical staff. Despite the detailed information requested, certain information had only been partially recorded or not recorded at all.

Staff informed the delegation that practical training on the use of restraints was part of the initial training at the Police Academy; however, for most of them, this training had not been followed up.

83. At Ringerike Prison, the registers revealed that the security cells had been used 29 times in 2004 and 42 times in 2005 (1 January to 6 October). The restraining bed had been used very rarely (twice in 2004 and on six occasions in 2005). Every use of the security cells or the restraining bed was registered in detail in a special journal. Except in urgent cases, the decision to apply means of restraint was taken by the prison Governor (or by the head of the unit, under specific delegation). The decision on the prolongation/discontinuance of the measure was assessed daily. The length of stay in the security cells was, on average, 24 hours. As regards the restraining bed, its use was limited to a few hours.

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<sup>85</sup> Cf. Section 38 of the Execution of Sentences Act, and guidelines 3-4.

<sup>86</sup> Cf. CPT/Inf (94) 11, paragraph 118.

<sup>87</sup> According to the information obtained, it was not a question of permanent surveillance; entry into the cell and subsequent fixation were monitored, then all entries into/exits from the cell.

84. Examination of the registers at Trondheim Prison revealed that the placement in security cells (and the termination of the measure) was decided solely by prison officers. Further, placement in such a cell could last for some time (up to 17 days). In addition, important data was occasionally missing (such as the initial reason for restraints, the time of release, the subsequent location of the transferred prisoner, etc.). Moreover, in a number of cases, the medical opinion required by law had apparently not been requested and health-care staff had not seen the inmate, either prior to the implementation of the measure, or during his stay in the security cell. The situation was even worse as regards the medical monitoring of the use of the restraining bed.<sup>88</sup>

The delegation was informed that custodial staff would visually check inmates fixated in a restraining bed at least once per hour and that cell doors would only be opened in life-threatening situations, with at least three prison officers being present. Once calmed down, inmates would be transferred to one of the two neighbouring security cells or would return to their usual prison accommodation.

85. The CPT acknowledges that prison staff will on occasion have to use force to control violent prisoners and, exceptionally, may even need to resort to instruments of physical restraint. These are clearly high-risk situations as regards the possible ill-treatment of prisoners and, as such, call for specific safeguards.

A prisoner against whom any means of force have been used should have the right to be immediately examined and, if necessary, treated by a doctor. This examination should be conducted out of the hearing and preferably out of the sight of non-medical staff, and the results of the examination (including any relevant statements by the prisoner and the doctor's conclusions) should be formally recorded and made available to the prisoner. In those rare cases where resort to instruments of physical restraint is required, the prisoner concerned should be kept under constant, direct and personal supervision. Further, instruments of restraint should be removed at the earliest possible opportunity; they should never be applied, or their application prolonged, as punishment. Finally, a record should be kept of every instance of the use of force against prisoners.

**The CPT recommends that the policy on and practice of the use of restraint be reviewed at Trondheim Prison, in the light of the above criteria. Further, the forms used at Ila Prison to register the use of security cells/the restraining bed should be scrupulously completed.**

**The CPT also recommends that practical training sessions on the use of restraint be organised for prison staff throughout the Norwegian prison system.**

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<sup>88</sup> By way of example, the delegation found that one inmate had been restrained in such a bed while suffering from severe epileptic fits, without any medical opinion/supervision.

## 8. Contact with the outside world

86. Remand prisoners not subject to restrictions and sentenced prisoners were able to maintain reasonably good contact with their family and friends through visits, telephone calls and correspondence. In principle, they were allowed a minimum of 90 minutes of visits per week, and could make phone calls for up to 20 minutes per week (those with children could make phone calls for 40 minutes each week).

Pursuant to the legislation in force,<sup>89</sup> telephone calls were, in principle, monitored in all three establishments visited; consequently, they had to be made in a language understood by staff (either Norwegian or English). Interpretation was arranged if a prisoner could not speak one of these two languages; by way of example, at Ringerike Prison foreign prisoners were entitled to one such 30-minute phone call per month. However, in order to limit the interpretation costs, foreign prisoners at Ila Prison were not able to make any phone calls at all. **The CPT recommends that measures be taken to offer foreign prisoners at Ila Prison interpretation arrangements similar to those in place at Ringerike Prison.**

87. The delegation was informed that at Ringerike Prison, obligatory full body searches (when prisoners were instructed to completely undress and stand above a mirror in order for their bodily orifices to be checked) were carried out before and after each visit, sometimes in the presence of female personnel. **The CPT recommends that steps be taken immediately to ensure that female personnel are never present during full body searches of male prisoners at Ringerike Prison.**

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<sup>89</sup> Cf. Section 32 (2) of the Execution of Sentences Act.

## C. Psychiatric establishments

### 1. Preliminary remarks

88. At the end of the 1990s, there was a broad acknowledgement that Norway was facing challenges in providing adequate care for people suffering from mental health problems, and that the health system in particular had not succeeded in creating comprehensive alternative services to compensate for the closing-down of long-term hospitals.<sup>90</sup> An action plan for psychiatric health services was set in motion, the goal of which was to improve mental health services in general, to strengthen illness prevention and decentralise mental health care, to improve child and adolescent care, to stimulate education and research, and to reduce the number of involuntary psychiatric hospitalisations.<sup>91</sup> In 1999, a vast legislative reform accompanied this action plan, which took the form of four new acts: the Mental Health Care Act, the Patients' Rights Act, the Specialised Health Care Act and the Health Care Staff Act. The 2005 visit gave the CPT the opportunity to assess the implementation of the new mental health legislation, in particular as regards compulsory admission and treatment of patients in psychiatric establishments.

### 2. The new mental health legislation and related safeguards

#### a. initial placement decision

89. Under the new Mental Health Care Act (MHCA) 1999, Section 3 (7), *involuntary placement of a civil nature*<sup>92</sup> in a psychiatric establishment can be requested by a public authority or by the patient's closest relative. The request must be based on a written statement<sup>93</sup> made by a doctor. Consequently, involuntary placement in a psychiatric establishment is subject to a prior examination of the person concerned by a doctor (Section 3 (4) MHCA). The doctor must, in particular, ensure that the requirements for involuntary placement, as provided for by the law, are fulfilled. These requirements are set out in Section 3 (3) MHCA, which states that: the person has to suffer from a serious mental disease and the placement should be carried out to prevent his mental illness from reducing the chances of a cure or considerable improvement, or if it is likely that the person concerned would suffer an imminent aggravation of his condition, or if the person presents an imminent and serious danger to his or other people's life and health.

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<sup>90</sup> "Health Care Systems in Transition - Norway", European Observatory on Health Care Systems, 2000, page 69.

<sup>91</sup> In the past, Norway has had high rates of compulsory psychiatric admissions (for example, some 47% of all admissions to psychiatric hospitals in 1996 were compulsory). See, in particular, "Compulsory admissions to psychiatric hospitals in Norway - international comparisons and regional variations", *Journal of Mental Health* (2002) 11, 6, pages 623-634.

<sup>92</sup> As opposed to the - rare - cases of involuntary placement by court decision under the Penal Code (cf. paragraph 97).

<sup>93</sup> In the event of an emergency, the patient can also be admitted on the basis of a verbal request and a verbal statement from a doctor, provided that the relevant documentation is presented within 24 hours of the patient's arrival at the institution.

90. If the person refuses such a medical examination, the law allows for a compulsory examination (Section 3 (5) MHCA). Decisions on compulsory examination are taken by the Chief Municipal medical officer, on his own initiative or at the request of another public authority or the patient's closest relative. The examination itself must be carried out by another doctor. The Chief Municipal medical officer's decision may be appealed to the Chief County officer.

91. If, after a personal examination of the person concerned, the doctor is in doubt as to whether the conditions for involuntary placement are fulfilled and deems further examination (an observation period) necessary, the public authority or the patient's closest relative may request that the person be examined in an institution which has been approved for this purpose (Section 3 (6) MHCA). The decision on further examination is made by the mental health professional in charge of the institution. On the basis of the request and the medical information and opinion submitted, the latter will decide whether the person concerned shall be involuntarily placed under mental health care or be subject to an observation period of up to ten days (Section 3 (8) MHCA). Both decisions can be appealed to the Control Commission (cf. paragraphs 94 and 96), by the patient concerned, his closest family member, or the public authority. Further, the decisions of the Control Commission can be appealed in court, pursuant to Chapter 33 of the 1915 Civil Procedure Act.

92. The CPT welcomes the many improvements which have been introduced into the mental health legislation in Norway since its last visit. In particular, the implementation of the new Mental Health Care Act has substantially reduced the number of involuntary admissions in psychiatric establishments and the Patients' Rights Act has enshrined some fundamental rights.<sup>94</sup>

However, the CPT has some misgivings concerning the professional qualifications of persons involved in the involuntary placement procedure. As far as the delegation could ascertain, the decision as to whether a person should be placed under compulsory mental health care (or should be subject to an observation period) may be taken by a psychologist with clinical experience.<sup>95</sup> In the CPT's opinion, **such a decision should always remain exclusively in the hands of a qualified psychiatrist (and preferably two).**<sup>96</sup>

93. In its 8<sup>th</sup> General Report, the CPT highlighted the role of the judicial authorities in any involuntary placement procedure in a psychiatric establishment. In many countries, the decision regarding involuntary placement must be taken by a judicial authority (or confirmed by such an authority within a short time-limit), in the light of psychiatric opinions; however, the automatic involvement of a judicial authority in the initial decision on placement is not provided for in all countries, as is the case in Norway.

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<sup>94</sup> In particular, the right to health care, the right to participation and information, the right of access to medical records, consent to health care, complaints, the counties' patient's Ombudsman, etc.

<sup>95</sup> Cf. "Regulations regarding the professional responsible for taking decisions in mental health care", 1 December 2000, Sections 3-5.

<sup>96</sup> Cf. CPT/Inf (2000) 15, paragraph 59.

94. The CPT took note that the new Mental Health Care Act 1999 has expanded the tasks of the Control Commission<sup>97</sup> as an appeal body, while the supervisory function has apparently been attenuated.<sup>98</sup> However, it still remains an administrative body,<sup>99</sup> composed of a lawyer, a medical doctor and two lay persons. It is noteworthy that none of the members of the Control Commission have qualifications in psychiatry, despite the fact that such bodies are now involved in highly specialised psychiatric assessments, diagnosis, and deciding on the need for treatment/discharge of patients.<sup>100</sup> Consequently, **the CPT recommends that at least one member of each Control Commission be a qualified psychiatrist, independent of the institution under scrutiny.**

95. The CPT has also misgivings concerning the possibility offered to involuntary patients to challenge the lawfulness of their deprivation of liberty pursuant to Chapter 33 of the 1915 Civil Procedure Act. Although this possibility exists and has been used on several occasions, as far as the delegation could ascertain such appeals took on average two months (and at least six weeks). Furthermore, it is unclear to the Committee whether the patient has the right to challenge the involuntary placement decision directly in the courts, without having exhausted the remedy provided for by the Control Commission. **The CPT would like to receive further clarification from the Norwegian authorities in this respect.**

b. discharge

96. The mental health professional in charge continuously assesses whether or not the patient needs compulsory mental health protection (i.e. if the requirements for involuntary placement prescribed by law are still present). Moreover, the patient himself or his closest relative may, at any time, request that the involuntary placement measure be terminated, by way of an appeal to the Control Commission. For its part, the Control Commission assesses on its own initiative, every three months, whether there is an ongoing need for compulsory care. The involuntary placement measure ends after one year, unless the Control Commission agrees to extend it. The latter decision is valid for one year at a time.

The above-mentioned functions of the Control Commission highlight once again the need for it to have an independent qualified psychiatrist among its members (cf. paragraph 94).

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<sup>97</sup> The CPT welcomes the commitment and dedication of the members of the Control Commission met at Sør-Trøndelag Psychiatric Hospital, as well as their frequent presence in the establishment.

<sup>98</sup> Cf. CPT/Inf (2000) 16, page 23.

<sup>99</sup> "Health Care Systems in Transition - Norway", European Observatory on Health Care Systems, 2000, page 69.

<sup>100</sup> For example, a meeting note of the Control Commission at Sør-Trøndelag Psychiatric Hospital in Brøset stated in one particular case: "the Commission agrees .... that the patient had an emotionally unstable personality disorder, a state that borders on psychosis that affects a loss of the ability to cope and to assess reality. This is therefore a behavioural disturbance that is in line with a serious mental disorder. The basis for involuntary psychiatric care is thus in place".

### 3. Sør-Trøndelag Psychiatric Hospital

#### a. introduction

97. Sør-Trøndelag Psychiatric Hospital is situated in Brøset and is part of Trondheim St Olavs Hospital. Its catchment area covers the regions of Brøset and Ostmarka, the two northernmost regions of Norway. Built in 1929 and expanded in the sixties, the institution is spread over a large and well-kept park. Until the early seventies, the establishment used to be a forensic asylum for up to 300 patients (*Reitgerdet*).

The hospital has three wards: two high-security wards (A and B) and one medium-security ward (C). With an official total capacity of 18 patients, it was accommodating twelve involuntary patients<sup>101</sup> and three voluntary patients on the first day of the visit. The management's intention is that wards operate at around 60% of their capacity, in order to keep a number of beds free in case of need.

The delegation also visited two forensic patients detained in Ward F. As such, Ward F is not part of the hospital and is under the supervision of the recently created National Institute for Mandatory Care.<sup>102</sup> The official capacity of Ward F was five beds.

98. At the outset, it should be clearly stated that the CPT's delegation did not receive any allegations of deliberate physical ill-treatment of patients by staff at the establishment. On the contrary, it was impressed by the relaxed staff-patient relations and the commitment of staff to provide the best possible care. However, the CPT has some concerns as regards the use of means of restraint in the establishment (cf. paragraphs 106 to 109).

#### b. patients' living conditions, treatment and staff

99. Living conditions in Wards A, B, C and F were of a very high standard. The single occupancy rooms were spacious (8 to 18m<sup>2</sup>) and personalised. They were also well equipped (bed, chair, desk, armchair, cupboard, locker). Moreover, each room had its own partitioned toilet and had adequate access to natural light and artificial lighting. The premises were well heated and ventilated and patients could also use bigger lockers in the adjacent corridors.

Similarly, communal areas were pleasant, spacious and nicely decorated with paintings and plants. In addition, each ward had its own kitchen. The delegation was also impressed by the overall state of cleanliness and hygiene throughout the establishment, including the sanitary facilities, which were fully in line with hospital standards.

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<sup>101</sup> They were mostly long-term patients, accommodated for longer than one year.

<sup>102</sup> The National Institute for Mandatory Care is the only unit focusing on the mandatory care of offenders with learning disabilities. Patients in Ward F had been placed in the establishment pursuant to Section 39 of the Penal Code. The placement may take place for preventive purposes or after the person concerned has served all or part of his sentence.



100. Psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient indicating the goals of the treatment, the therapeutic means used and the staff member responsible. The treatment plan should also include regular reviews of the patient's mental health condition and of his medication.

It should involve a wide range of therapeutic, rehabilitative and recreational activities, such as access to occupational therapy, group therapy, individual psychotherapy, art, drama, music and sports. Patients should have regular access to suitably-equipped recreation rooms and have the possibility to take outdoor exercise on a daily basis.

101. All patients had their own medical file, containing an individual treatment plan; however, some of the latter were rather cursory. Patients received the psycho-pharmacological medication required by their state of health, and no indication of overmedication was found. Regular consultations were held between the patients and their psychiatrist.

Genuine efforts were also made to involve as many patients as possible in a wide range of therapeutic and rehabilitative activities. These activities, based on an individualised approach, included occupational therapy (sewing, knitting, weaving, cooking, carpentry), group therapy and outdoor activities, including sport (football, handball, volleyball), and - depending on the condition of the patients - visits to a variety of cultural institutions. Moreover, patients had access to a well-equipped gym, indoor hall, sauna and swimming pool, as well as to TV, video games, CD players, newspapers and books from the well-stocked library.

102. It should also be underlined that under the new MHCA 1999, a decision on involuntary placement did not automatically empower the authority to carry out an examination or give medication or any other treatment without the patient's consent. Involuntary examination, medication or other treatment requires a separate administrative decision (Section 4 (4) MHCA), which is taken by the mental health professional in charge and can be appealed to the Chief County medical doctor.

103. On admission, patients were placed in one of the nine security levels used in the establishment.<sup>103</sup> The security levels were frequently reviewed by the hospital management; however, several patients alleged that they had not been fully informed about the security levels and the restrictions on rights related to them, as well as how to contest their security status. **The CPT would like to receive the comments of the authorities on this issue.**

104. The delegation was informed that serious difficulties occurred whenever the authorities considered a possible transfer from a voluntary to a compulsory placement status. It appeared that, in its present state, the legislation required the patient concerned to be discharged first, before the procedure for involuntary placement could be started. Pending the necessary administrative arrangements, the patient was held in the institution on the "principle of necessity". **The CPT would like to receive more information on this issue.**

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<sup>103</sup> For example: 00-special surveillance (constant supervision); 0-leave inside fenced area with assistance; 1-participation in activities inside the occupational therapy building; 2-leave with assistance in hospital area (before dark); ...7-permission (day/night) by special appointment.

105. Staff resources in Wards A, B and C, were adequate in terms of numbers, categories of staff, experience and training. The average ratio of staff was five staff members to one patient, which was apparently double that in other civil psychiatric hospitals.

c. means of restraint

106. In any psychiatric establishment, the restraint of agitated and/or violent patients may on occasion be necessary. This is an area of particular concern to the CPT, given the potential for abuse and ill-treatment.

The new MHCA 1999, Section 4 (8), provides for the following means of restraint: (a) mechanical means of coercion which limit the patients' freedom of movement, including belts and straps and special clothes to prevent self-mutilation; (b) *short periods*<sup>104</sup> of confinement behind a locked door without the presence of staff ("shielding"), and (c) a single dose of medication with the short-term effect of calming down the patient.

The decision to restrain a patient must be taken by a doctor (except in emergencies where the doctor is contacted immediately) and the patient remains under the constant surveillance of nursing staff. Furthermore, such a decision is recorded in writing and can be appealed to the local Control Commission.

The above-mentioned provisions are in principle consistent with the CPT's standards in this area.<sup>105</sup> However, the manner in which they have been applied in certain cases at the establishment is of concern to the Committee.

107. The delegation came across the case of a patient of Iranian origin, suffering from a severe form of post-traumatic-stress disorder (PTSD), who had been held under restraint for some 750 hours over a period of 40 days (approximately 30 days out of 40).<sup>106</sup> The patient concerned had been bound with straps, or had one foot and one hand tied to a bed, for prolonged periods, as he regularly attacked the staff and injured himself on numerous occasions despite being heavily sedated with psycho-active medication. The fact that one staff member could communicate with him in his mother tongue did not alleviate the problem.

The CPT fully recognises that in exceptional cases resort to instruments of physical restraint may be required. However, a state of affairs such as the one described above cannot have any therapeutic justification and could amount, in its view, to ill-treatment. The hospital management informed the delegation of its intention to review the treatment offered to the patient in question. **The Committee would like to be informed of the conclusions of that review and of any measures taken to avoid the repetition of such a case.**

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<sup>104</sup> Emphasis added.

<sup>105</sup> Cf. 8<sup>th</sup> General Report, paragraphs 47-50 (CPT/Inf (98) 12).

<sup>106</sup> During its previous visit to Norway, the CPT's delegation encountered a very similar case - an Algerian national who had been restrained for nearly four months - when visiting Dikemark Hospital. An adequate solution (i.e. more staff resources) had been found and the means of restraint were removed shortly after the CPT's visit.

108. As already indicated, Norwegian legislation provides for a form of seclusion, called "shielding". "Shielding" is mainly used when a patient becomes restless or aggressive, on a doctor's decision. In this context, it should be noted that the relevant regulations do not provide for the recording of the measure, when it is being employed for less than 48 hours. **The CPT recommends that all measures of "shielding", whatever their duration, be recorded in writing.**

Furthermore, although "shielding" was used very exceptionally (only five times since 2003), the delegation noted that it was possible for the same patient to be subjected to successive measures of "shielding" of up to 21 days, without any interruption. In one case, the "shielding" of a patient was maintained for 52 consecutive days. This is a highly debatable practice, which could hardly be reconciled with the "short periods" envisaged by the legislation in force (cf. paragraph 106). The existing maximum period of "shielding" provided by the relevant regulations is already quite high; **the CPT considers that such a measure should not be renewed without any interruption.**

109. The CPT would also like to raise the issue of the use of restraint vis-à-vis "voluntary" patients. Restrained patients are in fact involuntary patients and their legal status should be regulated accordingly. **The CPT recommends that the Norwegian authorities take the necessary steps to ensure that this is the case.**

d. other issues

110. In their response to the 1999 visit report, the Norwegian authorities indicated that "an introductory brochure will to a large extent contribute to greater knowledge among patients and their relatives regarding legal rights".<sup>107</sup> However, no such introductory brochure was available to patients and their families at the time of the visit. **The CPT reiterates its recommendation that introductory brochures - setting out the establishment's routine as well as patients' rights and possible restrictions on these rights - be drawn up and issued to all patients admitted involuntarily to a psychiatric establishment in Norway, as well as to their families. Any patient unable to understand the brochure should receive appropriate assistance.**

111. Contact with the outside world was adequate in respect of correspondence and phone calls: patients could send/receive an unlimited number of letters, and a card phone was available to all patients (patients on Ward C were even allowed to keep their own mobile phones). However, Section 4 (5) (3) MHCA provides that, apart from the "reasonable limitations" provided for by house rules, the patient's communication with, *inter alia*, the Control Commission, the Patients' Ombudsman and his lawyer cannot be restricted. **The CPT would like to receive detailed information on the nature of the above "reasonable limitations".**

112. Patients could also receive visits every day, in a nicely decorated room situated in Ward C, which could accommodate up to six persons. However, the delegation was informed that health care staff were systematically present during such visits, mainly for security reasons. Some of the patients met by the delegation were unhappy with this practice, which they felt prevented them from maintaining at least a minimum level of privacy with their closest relatives.

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<sup>107</sup> Cf. CPT/Inf (2000) 16, page 22.

The CPT acknowledges that special security measures may be required during visits in certain cases, especially if there is a history of violence between a patient and his visitors, or if a security threat (drug smuggling, etc.) is perceived by the health-care staff. However, there can be no justification for health-care staff being systematically present during such visits. Alternative solutions can and should be found to reconcile legitimate security requirements with privacy. **The CPT recommends that the Norwegian authorities reconsider the value of the systematic presence of health-care staff during visits. One possible solution would be for visits to remain within the sight, but not the hearing, of staff, thus enabling the patients to establish a certain degree of privacy in their contacts with their relatives.**

113. The CPT's delegation was informed about plans to transfer the hospital and merge it with the psychiatric ward of a neighbouring general hospital. The uncertainty surrounding the conditions of this transfer was creating a certain amount of tension among staff, as they apparently feared that "they would not be in a position to offer an individualised treatment to patients". **The CPT would like to be informed of any developments in this respect (and in particular of the material conditions and treatment offered to patients after the transfer, staffing levels, etc.).**

114. The CPT's delegation was also informed that the authorities were envisaging amendments to the Mental Health Care Act. **The Committee would like to be informed of these amendments, once they are adopted.**

**APPENDIX I**

**LIST OF THE CPT'S RECOMMENDATIONS, COMMENTS  
AND REQUESTS FOR INFORMATION**

**A. Police establishments**

**Preliminary remarks**

comments

- the objective should be to put an end, except in exceptional circumstances, to the practice of accommodating remand prisoners in police establishments (paragraph 10).

requests for information

- the entry into force of Section 183 (amended) of the Criminal Procedure Act and a copy of its implementing regulations (paragraph 8).

**Ill-treatment**

requests for information

- copies, as soon as they are completed, of both the final report by the Special Investigation Unit and the final autopsy report concerning the death during the night of 3-4 October 2005 of a person detained in the Central Police Station in Kristiansand (paragraph 13);
- comments on the complaints received that police officers place handcuffs on the wrists or ankles of persons having to be escorted from home to a psychiatric clinic, even where they put up no resistance (paragraph 14).

**Safeguards against ill-treatment**

recommendations

- the necessary steps to be taken to ensure the strict application, in all police establishments, of paragraph VII.1.a of Circular No. 5/2002 issued by the Director General of Public Prosecutions on 15 November 2002, regarding the right to inform a close relative or a third party of one's deprivation of liberty (paragraph 16);

- Circular No. 5/2002 to be revised in order to guarantee expressly that any decision to defer, as an exceptional measure, the exercise of the right to inform a close relative or a third party of one's deprivation of liberty, is subject to the approval of a senior police officer or a prosecutor and strictly limited in time (paragraph 17);
- the necessary steps to be taken to ensure that all persons held by the police, irrespective of the reason for their apprehension, are expressly guaranteed the right to notify a close relative or a third party of their choice of their situation, from the very outset of their deprivation of liberty (paragraph 18);
- the Norwegian authorities to ensure that the right of access to a lawyer, as defined in paragraph 20:
  - is formally granted to everyone deprived of their liberty by the law enforcement authorities (including those apprehended under the Police Act) from the very outset of their deprivation of liberty, and
  - is made fully effective in practice (paragraph 20);
- express reference to be made to the principle requiring that any medical examination of a person in police custody should be conducted out of the hearing and - unless the doctor concerned expressly requests otherwise in a specific case - out of the sight of the police (paragraph 23);
- the necessary steps to be taken to ensure that the guidelines set out in Circular G-67/2000 of the Ministry of Justice and the Police are strictly applied in all police establishments (paragraph 23);
- the necessary steps to be taken to ensure that all persons detained by the police (including those apprehended under the Police Act) are informed in writing of their rights, at the very outset of their deprivation of liberty. Furthermore, the persons concerned should sign a statement attesting that they have been informed of their rights in a language which they understand (paragraph 24).

requests for information

- the outcome of the work aimed at the introduction of sound and video recording of police interviews (paragraph 25);
- whether the Special Investigation Unit still has on its permanent staff persons "on leave" from their posts in the police (paragraph 26).

## **Conditions of detention**

### recommendations

- immediate steps to be taken to ensure that:
  - all persons obliged to stay overnight in a police establishment receive a mattress and clean blankets, without needing to ask;
  - all persons held in a police establishment are given food at normal mealtimes, including a full meal (i.e. something more substantial than a sandwich) at least once a day (paragraph 29);
- the metal ring, or any similar device, fixed to the wall beside the bed in some police cells to be removed (paragraph 30).

### requests for information

- whether the building works at Oslo Police District Headquarters include an outdoor exercise area for detained persons (paragraph 31).

## **Trandum Aliens Holding Centre**

### recommendations

- the necessary steps to be taken to ensure that all persons held at the Centre (including persons in the "security" section) are able to take at least one hour of outdoor exercise a day (paragraph 34);
- steps to be taken to ensure that the foreign nationals held at the Centre receive appropriate psychological and/or psychiatric services, preferably by having a psychologist and/or a psychiatrist regularly available for consultation at the Centre (paragraph 37);
- at least one part-time nurse's post to be created. The nursing staff could, for instance, conduct the initial medical interview of new arrivals (which should be systematic), manage the medical records, assemble the requests for consultations (inside and outside the Centre), prepare medicines and ensure their distribution (paragraph 38);
- the practice of performing a medical examination before deportation to be extended to all deportation operations by air. Furthermore, all persons who have been the subject of an abortive deportation operation should undergo a medical examination as soon as they are returned to detention (paragraph 40);

- the instructions relating to the "security" section of the Centre to be revised, in the light of the remarks made in paragraphs 34 and 44. It would, *inter alia*, be advisable for the instructions to distinguish clearly the different types of placement in use (voluntary or involuntary isolation, isolation for health reasons, isolation as a disciplinary measure) and the related procedures and guarantees; in particular, it would be unacceptable for a person placed in the "security" section to be denied access to his lawyer. These instructions - translated into an appropriate range of languages - should be at the disposal of the foreign nationals held at the Centre (paragraph 45);
- a specific register to be kept in the "security" section, containing information on the identity of the person placed in isolation, grounds for the measure, date and time the measure began and ended, means of restraint (if used), the authority which took the decision, and the precise location where the detainee was placed (paragraph 45).

#### comments

- the Norwegian authorities are invited to reduce the occupancy rate in the bedrooms of the male section (paragraph 33);
- there were no lockable wardrobes or tables and chairs in the men's bedrooms (paragraph 33);
- the Norwegian authorities are invited to pursue their efforts to extend the activities offered to long-term detainees at the Centre. In this respect, measures should be taken (upkeep of equipment, presence of staff) to ensure regular access to the facilities already in existence, in particular the sports rooms (paragraph 35);
- in their present state, the two "bare" cells in the "security" section are unsuitable for detention of any kind (paragraph 41).

#### requests for information

- whether the persons employed by the private security firm also receive appropriate training (paragraph 36);
- detailed information on the applicable regulations and practice as regards the administration of medicines to persons subject to a deportation order (paragraph 40);
- detailed information on the policy and practice regarding the use of wrist and ankle strips inside the "security" section (protocol/instructions, as well as statistics for 2005) (paragraph 45).



## **B. Prisons**

### **Ill-treatment**

#### requests for information

- detailed information on the extent of inter-prisoner violence in Norwegian prisons, and specifically at Trondheim Prison, as well as on the strategies applied to address this phenomenon (paragraph 50).

### **Court-ordered solitary confinement of remand prisoners and other restrictions**

#### recommendations

- during each periodic review by the court of the necessity to maintain remand in custody, whether the restrictions imposed upon a remand prisoner should be maintained to be reconsidered (paragraph 53);
- the strict application of Circular No. 5/2002 issued by the Director General of Public Prosecutions on 15 November 2002 to be ensured. It would be particularly advisable to issue a firm reminder to the prosecutors and members of the police concerned that it is inadmissible to apply or to maintain restrictions for the purpose of pressuring a person remanded in custody to co-operate in the police investigation (paragraph 54);
- the efforts to be pursued to provide activities and appropriate human contact for remand prisoners held in solitary confinement and/or under restrictions (paragraph 56).

#### comments

- the Criminal Procedure Act should stipulate an absolute upper limit on the duration of solitary confinement of remand prisoners by court order (paragraph 52).

### **Conditions of detention**

#### recommendations

- immediate steps to be taken to ensure that female inmates at Trondheim Prison enjoy unrestricted access to the lavatory at all times, day or night; ideally, they should have the use of in-cell toilet facilities which are partitioned off (paragraph 59);
- measures to be taken at Ringerike and Trondheim Prisons to ensure that all prisoners (sentenced or on remand, male or female) spend a reasonable part of the day outside their cells, engaged in purposeful activities of a varied nature (paragraph 66);

- the programme of activities at the very high security unit of Ringerike Prison to be reviewed, in the light of the comments in paragraph 67 and the principles set out by the CPT in this area (cf. 11<sup>th</sup> General Report, CPT/Inf (2001) 16, paragraph 32) (paragraph 67).

#### comments

- the sports room in the women's unit at Trondheim Prison had no ventilation system (paragraph 60);
- the CPT has misgivings about the outdoor exercise areas at the very high security unit of Ringerike Prison (paragraph 60).

#### requests for information

- comments on the issue raised in paragraph 68, as well as detailed information on the legal basis for such special security measures (paragraph 68).

#### **Staffing issues**

#### recommendations

- a survey to be carried out on the phenomenon of absenteeism among custodial staff at Ringerike and Trondheim Prisons (and, if deemed necessary, throughout the whole prison system) (paragraph 69).

#### comments

- the Norwegian authorities are invited to reconsider the minimum level of staffing at night at Ila, Ringerike and Trondheim Prisons (paragraph 70).

#### requests for information

- a copy of the survey on the phenomenon of absenteeism among custodial staff (paragraph 69).

## **Medical services**

### recommendations

- immediate steps to be taken at Ila, Ringerike and Trondheim Prisons to ensure that every newly-admitted prisoner - whether sentenced or on remand - is properly interviewed and physically examined by a medical doctor as soon as possible after admission; save in exceptional circumstances, the interview/examination should be carried out on the day of admission. Such medical screening could also be performed by a fully qualified nurse reporting to a doctor; however, this should not unduly delay the interview with the doctor (paragraph 73);
- in the light of the comments in paragraphs 74 and 75, substantially increase the provision of psychological/psychiatric services at Ila, Ringerike and Trondheim Prisons. In particular, immediate measures should be taken to ensure regular visits by a psychiatrist to Trondheim Prison (paragraph 75);
- steps to be taken to ensure that prisoners suffering from a mental illness are transferred when necessary to an appropriate hospital establishment (paragraph 76);
- the services of a qualified interpreter to be made available without delay, whenever members of the medical and/or nursing staff at Trondheim Prison are unable to make a proper diagnosis due to language problems (paragraph 77);
- measures to be taken to guarantee that all medical examinations of prisoners (whether on arrival or at a later stage) are conducted out of the hearing and - unless the doctor concerned requests otherwise in a particular case - out of the sight of prison officers (paragraph 78).

### comments

- Ringerike and Trondheim Prisons should each benefit from a half-time medical doctor's post (paragraph 72);
- the nursing team at Trondheim Prison should be reinforced to the level of three full-time nursing posts (paragraph 72).

### requests for information

- comments on the complaints from foreign prisoners at Trondheim Prison indicating that they had to request special prison leave to obtain access to outpatient specialised care (paragraph 77);
- a copy of the second autopsy report concerning the female prisoner who died on 8 September 2005 at St Olavs Hospital, two days after having been transferred there from Trondheim Prison (paragraph 79).

## **Means of restraint/Isolation**

### recommendations

- the policy on and practice of the use of restraint to be reviewed at Trondheim Prison, in the light of the criteria set out in paragraph 85. Further, the forms used at Ila Prison to register the use of security cells/the restraining bed should be scrupulously completed (paragraph 85);
- practical training sessions on the use of restraint to be organised for prison staff throughout the Norwegian prison system (paragraph 85).

## **Contact with the outside world**

### recommendations

- measures to be taken to offer foreign prisoners at Ila Prison interpretation arrangements similar to those in place at Ringerike Prison (paragraph 86);
- steps to be taken immediately to ensure that female personnel are never present during full body searches of male prisoners at Ringerike Prison (paragraph 87).

## **C. Psychiatric establishments**

### **The new mental health legislation and related safeguards**

#### recommendations

- at least one member of each Control Commission to be a qualified psychiatrist, independent of the institution under scrutiny (paragraph 94).

#### comments

- the decision as to whether a person should be placed under compulsory mental health care (or should be subject to an observation period) should always remain exclusively in the hands of a qualified psychiatrist (and preferably two) (paragraph 92).

#### requests for information

- whether patients have the right to challenge an involuntary placement decision directly in the courts, without having exhausted the remedy provided for by the Control Commission (paragraph 95).

## **Sør-Trøndelag Psychiatric Hospital**

### recommendations

- all measures of "shielding", whatever their duration, to be recorded in writing (paragraph 108);
- the necessary steps to be taken to ensure that the legal status of "voluntary" patients subject to restraint is regulated accordingly (paragraph 109);
- introductory brochures - setting out the establishment's routine as well as patients' rights and possible restrictions on these rights - to be drawn up and issued to all patients admitted involuntarily to a psychiatric establishment in Norway, as well as to their families. Any patient unable to understand the brochure should receive appropriate assistance (paragraph 110);
- the value of the systematic presence of health-care staff during visits to be reconsidered. One possible solution would be for visits to remain within the sight, but not the hearing, of staff, thus enabling the patients to establish a certain degree of privacy in their contacts with their relatives (paragraph 112).

### comments

- patients should not be subjected to successive measures of "shielding" without any interruption (paragraph 108).

### requests for information

- comments on the information given to patients about the security levels (paragraph 103);
- more information on the procedure for a transfer from a voluntary to a compulsory placement status (paragraph 104);
- the conclusions of the review regarding the treatment offered to a patient to whom instruments of physical restraint had been applied for approximately 30 days out of 40, and information on any measures taken to avoid the repetition of such a case (paragraph 107);
- detailed information on the nature of the "reasonable limitations" on contact with the outside world referred to in Section 4 (5) (3) MHCA (paragraph 111);
- any developments as regards plans to transfer the hospital and merge it with the psychiatric ward of a neighbouring general hospital (and in particular of the material conditions and treatment offered to patients after the transfer, staffing levels, etc.) (paragraph 113);
- copy of the amendments to the Mental Health Care Act, once they are adopted (paragraph 114).

## APPENDIX II

### **LIST OF THE GOVERNMENTAL AUTHORITIES, OTHER AUTHORITIES AND NON-GOVERNMENTAL ORGANISATIONS WITH WHICH THE CPT'S DELEGATION HELD CONSULTATIONS**

#### **A. Governmental authorities**

##### Ministry of Justice and the Police

- |   |                          |                                     |
|---|--------------------------|-------------------------------------|
| - | Odd Einar Dørum          | Minister                            |
| - | Morten Ruud              | Secretary General                   |
| - | Kristin Bølgén Bronebakk | Director General                    |
| - | Tom Brunsell             | Acting Director General             |
| - | Tor-Aksel Busch          | Director of Public Prosecutions     |
| - | Ingelin Killengreen      | National Police Commissioner        |
| - | Vidar Refvik             | Deputy National Police Commissioner |

##### Ministry of Health and Care Services

- |   |                        |                                  |
|---|------------------------|----------------------------------|
| - | Jan Otto Risebrobakken | State Secretary, Deputy Minister |
| - | Hans-Jacob Sandsberg   | Deputy Director General          |
| - | Anne-Grete Kvanvig     | Senior Adviser                   |
| - | Lars Duvaland          | Adviser                          |

##### Ministry of Labour and Social Affairs

- |   |                           |                                |
|---|---------------------------|--------------------------------|
| - | Knut Bjørn Christophersen | Deputy Director General        |
| - | Lilly Sofie Ottesen       | Acting Deputy Director General |

##### Ministry of Local Government and Regional Development

- |   |                         |                         |
|---|-------------------------|-------------------------|
| - | Cathrin Bretzeg         | State Secretary         |
| - | Sissil Maria Pettersen  | Deputy Director General |
| - | Solveig Paulsen         | Senior Adviser          |
| - | Anita Vardøy            | Senior Adviser          |
| - | Manuela Ramin Osmundsen | Deputy Director General |

**B. Other authorities**

Office of the Parliamentary Ombudsman

-	Arne Fliflet	Parliamentary Ombudsman
-	Eivind Sveum Brattegard	Head of Division
-	Henriette Lund Busch	Adviser
-	Jo Høvik	Adviser

Office of the Ombudsman for Children

-	Reidar Hjermann	Ombudsman for Children
-	Knut Haanes	Deputy Ombudsman for Children
-	Anette Storm Thorstensen	Senior Adviser
-	Frøydis Heyerdahl	Adviser
-	Arild Søggen	Adviser

**C. Non-Governmental Organisations**

Amnesty International Norway

Norwegian Association for Asylum Seekers

Norwegian Bar Association

Norwegian Helsinki Committee