SIVILOMBUDET

Norwegian Parliamentary Ombud

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

ANNUAL REPORT 2024

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The Year at a Glance

Ten years have passed since the establishment of the Norwegian National Preventive Mechanism (NPM). Over the course of these ten years, we have conducted more than a hundred visits to closed institutions within the prison service, the police, the health system, municipalities and child welfare services. The situation of prisoners was a high priority for the NPM when we started our work in 2014. Ten years later, we continue to prioritise the prison sector. In 2024, we visited five high-security prisons and spoke to more than 100 inmates and almost 130 staff members. These are conversations that make a difference.

The prison sector is characterised by several worrying and negative trends that contribute to an increased risk of violations. The extent of de facto solitary confinement among inmates due to lack of staff and limited activities is alarmingly high in all the prisons we have visited in recent years. We meet many inmates who spend large parts of the day locked up in their cells without any decision by the prison or the court.

In 2019, the NPM submitted a special report to the Storting on solitary confinement in prisons. Six years later, a high degree of de facto solitary confinement still characterises the prison service. Some measures have been taken to improve the situation for those placed in solitary confinement by a formal decision. At the same time, we see that the non-formal, de facto solitary confinement due to low staffing levels and building conditions continue, and in some places have worsened.

Detainees have shared their distress of spending long days alone in their cells without meaningful activity or meaningful human contact. Some react with despair or anger, others become apathetic and choose to withdraw themselves from the prison community. Some experience anxiety attacks and need medication to 'endure' the isolation. Prison isolation is harmful, regardless of whether it is caused by a formal decision or not. This year, we have visited prisons that keep prisoners without work or study placements locked in their cells for 18-20 hours a day. Norwegian regulations on the execution of sentences do not stipulate any minimum time inmates are to be locked out of their cells.

The issue of minors in prison has also been an important topic for us in the past year. The UN Convention on the Rights of the Child states that children should only be detained as a last resort. Generally, children in prison should also be kept separate from adults. During our visit to Eidsberg Prison, we found children left alone and unsupervised in a ward with adult inmates. No assessment was made as to whether it was in the best interest of the individual child to be detained with adult prisoners. The situation constituted a serious violation of the children's rights, and we urged the authorities to take immediate action to improve the situation.

In the area of mental health care, the NPM investigated a very serious case at Østfold Hospital, where we learned that a patient had been restrained in belt fixation for almost 41 consecutive days. We have engaged in an extensive written dialogue with the hospital and the Supervisory Commission about the patient's treatment. During the NPM's visit to the hospital in 2018, we also raised concerns about prolonged restraints. It is disconcerting that the hospital still does not appear to have changed its culture and practice regarding belt fixations and use of restraint measures. The belt-fixation practice in the hospital creates a high risk of violating article 3 of the European Convention on Human Rights. We have informed the hospital and relevant inspectorate bodies about our concern in the case and expect significant changes in how the hospital handles such cases in the future.

Hanne Harlem
Parliamentary Ombud

Photo: Mona Ødegård

Our Mandate

The prohibition on torture and other cruel, inhuman or degrading treatment or punishment is established in the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture). The same prohibition is also embodied in the UN International Covenant on Civil and Political Rights (Article 7), the UN Convention on the Rights of the Child (Article 37), the UN Convention on the Rights of Persons with Disabilities (Article 15) and the European Convention on Human Rights (Article 3). Norway has ratified all of these conventions.

People deprived of their liberty are vulnerable to violations of the prohibition against torture and inhuman treatment, which is why the UN adopted an Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in 2002.

The protocol requires that states establish a national preventive mechanism (NPM) to ensure that persons who are deprived of their liberty are not subjected to torture and other cruel, inhuman or degrading treatment or punishment.[1] In Norway, the NPM is established as a separate unit at the Parliamentary Ombud (Sivilombudet) in accordance with the Parliamentary Ombud Act of 2021.[2]

The NPM has access, and can conduct visits to all locations where persons are or may be deprived of their liberty. These places range from prisons and police custody facilities to mental health care institutions and child welfare institutions.

Visits are usually semi-unannounced, as the institution is told there will be a visit, but not exactly when it will occur. The NPM also has access to all necessary information of significance for how deprivation of liberty is implemented.

The risk of torture or inhuman treatment is affected by factors such as legal and institutional frameworks, physical conditions, training, resources, management, and institutional culture.[3] Effective prevention work, therefore, requires a broad approach that does not focus exclusively on whether the situation complies with Norwegian law. To ensure this broad perspective, the Norwegian NPM team is interdisciplinary and is made up of staff with backgrounds in law, psychology, and social sciences.

The NPM's assessments of conditions that pose a risk of torture and inhuman treatment stem from a broad range of sources. During the visits, we examine the conditions at the location through observations, interviews and documentation review. Private interviews with persons deprived of liberty are important sources of first-hand information about the conditions. Staff, management, and other relevant parties are also interviewed. Furthermore, documentation, such as guidelines, decisions, logs, and health documentation, is obtained to clarify the conditions at the location.

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

1 Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, articles 17-23.
2 Section 1, 17, 18 and 19 of the Norwegian Parliamentary Ombud Act.
3 UN Subcommittee on Prevention of Torture (SPT), Prevention Mandate Recommendations, 30 December 2010 CAT/OP/12/6.

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

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

From a prison visit. Photo: The Parliamentary Ombud/NPM

Our Work in Numbers

5 completed visits in 2024

103 interviews with prison inmates

126 interviews with staff working in prison

8 published reports from visits

1 thematic report

The National Preventive Mechanism at the Parliamentary Ombud. From the left: Aurora Geelmuyden, Lars Mathias Enger, Johannes Flisnes Nilsen, Karin Afeef, The Parliamentary Ombud Hanne Harlem, Helga Fastrup Ervik, Inga Laupstad, Mette Jansen Wannerstedt, Tonje Østvold Byhre. Photo: Mona Ødegård

Visits and Visit Reports in 2024

Visits in 2024

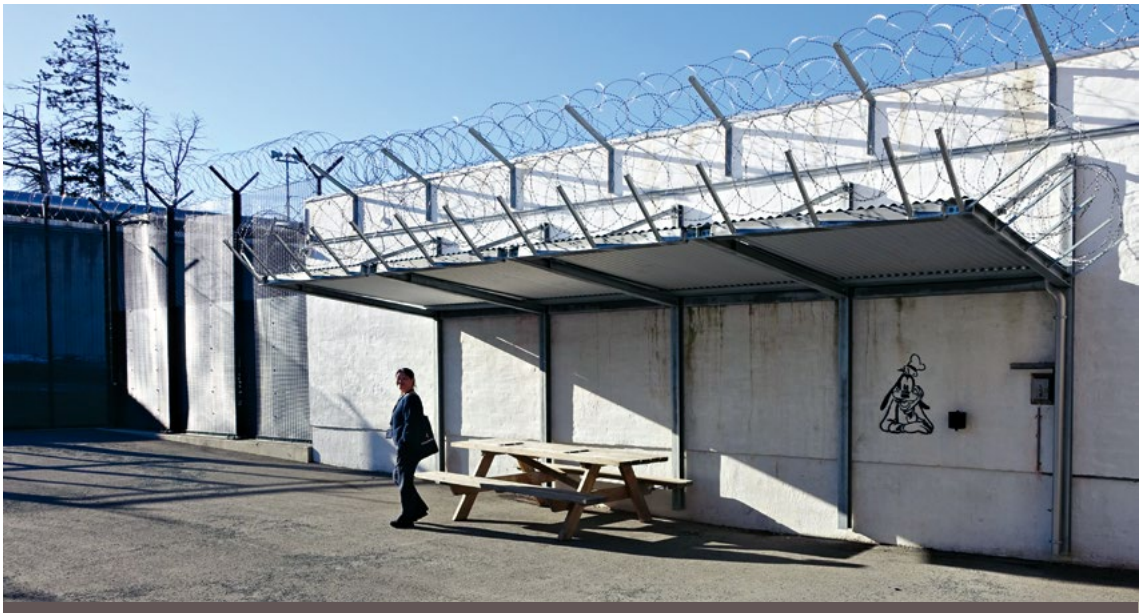
The core task of the National Prevention Mechanism (NPM) is to visit places where people are, or can be, deprived of their freedom. Our aim is to reduce the risk of torture or other cruel, inhuman or degrading treatment or punishment. This section provides information about the visits carried out in 2024.

Visits to prisons

In 2024, the NPM has prioritised visiting high-security prisons. Prisons are at the core of the NPM's mandate. Between 2014 and 2019, the NPM carried out 20 prison visits and summarised its main findings in a special report to the Storting on solitary confinement and lack of human contact in Norwegian prisons.

Following the submission of the special report in 2019, the NPM increased its focus on other places of deprivation of liberty.

Nevertheless, following our report in 2019, we received information from concerned inmates, staff, and relatives about the situation in various prisons. In 2023, we were informed of particularly challenging conditions for female inmates at Bredtveit high-security women's prison. This led to an urgent visit, during which we uncovered critical and life-threatening conditions that were immediately reported to the Ministry of Justice and Public Security.



A prison outdoor area. Photo: The Parliamentary Ombud/NPM

What is a NPM visit?

A visit process in the Norwegian NPM entails thorough preparations, including gathering extensive documentation, conducting physical visits over two to four days. After the visit we analyze our data and produce a visit report with reccomendations to the authorities. This is followed up by a dialogue with the institution visited.

The visit to Bredtveit prison marked the beginning of a series of new visits to high-security prisons across the country. In total, we have visited nine high-security prisons in 2023 and 2024. We have also completed a limited investigation into the living conditions for inmates in Oslo prison. The prisons varied in size, profile, and physical conditions.

Selected findings

› *Extensive lock-up regimes*

Our visits have revealed that a significant proportion of inmates in Norwegian prisons are locked up alone in their cells for large parts of the day. For most of them, this solitary confinement happens as part of the prison's ordinary schedule and is not due to the inmate's own behaviour. This is a worrying development, evident in all the prisons we have visited. Too many inmates are locked up for 18 to 22 hours a day, and they are at a high risk of being harmed by this regime.

One of the main reasons for the widespread confinement appears to be that staffing levels in most prisons have been reduced in recent years. Prison security considerations require officers to be present when inmates spend time together. Sometimes we see that activity rooms and exercise facilities cannot be used because no officers are available to accompany inmates to these parts of the prisons.

We have also noticed that several prisons lack sufficient school and workplace facilities to be able to provide a sufficient activity programme for everyone. This is caused by a lack of employees and inadequate physical space for adequate work operations and facilities.

› *Increased insecurity and self-isolation*

Lack of staffing also affects inmates' sense of security. At several prisons, we have spoken to inmates who felt unsafe in the company of other inmates, often because officers were not present. Several employees also told us about an increase in threats and violence both between inmates and against staff.

Increased insecurity also prompted many inmates to withdraw from social activities and community time outside their cell. In Ringerike prison, for example, the number of decisions on long-term solitary confinement had almost doubled in one year. Many of these cases involved inmates isolating themselves due to insecurity. In several prisons, we have met inmates who prefer to be isolated in a restrictive unit, rather than ordinary communal wards, because they feel unsafe with other inmates.

"Some people found the wards in the communal E-building so unsafe that they preferred to stay in a restrictive ward in the prison, although this meant increased lock-up times in the cell and fewer daily activities."

Report from Trondheim prison

"The prison did not have enough work placements for all inmates. Several inmates told us they had to wait weeks and months for a placement. Inmates without a placement were locked up for up to 19 hours a day and several experienced symptoms consistent with isolation-related harm, such as hallucinations."

(Report from Ringerike prison)

From the carpentry at Froland prison.
Photo: The Parliamentary Ombud/NPM

"Employees said that there were too few work opportunities and that the number of work placements on offer had decreased in recent years."

(Report from Halden prison)

"Although the prison could accommodate up to 200 inmates, there were only 129 full-time places on the prison's school or work programme. The prison therefore did not have the capacity to provide daily activities for everyone who wanted it."

(Report from Agder prison, Froland unit)

"The prison's daily schedule meant that many inmates were systematically locked up in their own cells for more than 18 hours a day on weekdays. During the weekends, almost all inmates were locked up for more than 19 hours. Systematic solitary confinement on this scale, for an indefinite period of time and without individual assessment, entails a risk of inmates being subjected to inhuman or degrading treatment."

(Report from Ålesund prison)

"At the time of the visit, the prison had not had enough prison staff for several months and had therefore introduced a very restrictive lock-up regime [...]. Inmates in the community wards who were not offered work or study placements were therefore locked up alone in their cells between 19 and 21 hours a day. At the time of the visit, this applied to up to two thirds of the inmates."

(Report from Indre Østfold Prison, Eidsberg unit)

› *Weaknesses in suicide prevention work*

It is well documented that prisoners are more prone to poor mental health and have a higher risk of suicide than the general population. Unfortunately, our visits to prisons have revealed persistent weaknesses in the prisons' suicide prevention work. Many of the challenges highlighted in our thematic report on suicide and self-harm in prisons (2023) still apply.[1]

In several prisons, we have seen that preventive measures are limited to more frequent supervision, control and the aversion of acute danger. Long-term protective measures such as reduced lock-up times, increased contact with family or increased physical activity are rarely used. Here, too, the demanding staffing situation in the prisons has a negative effect. In several prisons, staff reported that they did not have the time to support inmates with mental health challenges adequately.

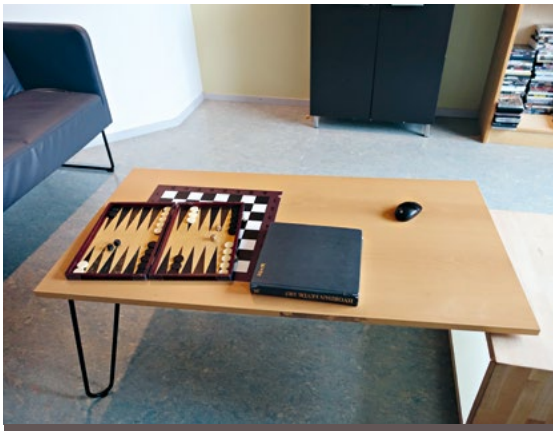
From a security cell in Trondheim prison.
Photo: The Parliamentary Ombud/NPM

We have also found several examples of suicidal inmates being placed in security cells as an acute preventive measure. Although the acute risk of suicide and self-harm can be limited when an inmate is placed in a naked cell, such isolation and use of force can also increase the risk of suicide, self-harm and the development of severe mental disorders. Using a security cell as a suicide prevention measure is therefore highly problematic.

Prison staff still have too little awareness of the risk associated with isolating suicidal inmates in security cells. In Trondheim prison, for example, we found that 15 out of 20 security cell decisions in 2023 were caused by suicide risk or self-harm. In Ringerike, 28 out of 35 security cell decisions in 2023 were prompted by suicide risk or self-harm. In Bodø and Trondheim prisons, we found cases where suicidal inmates had to remain naked in the security cell for an extended period of time. Several of the inmates we spoke to felt that, by being placed in a security cell, they were being penalised for sharing information about their mental health. This punitive response to suicide risk can also reduce the likelihood that inmates share information about their mental health with prison staff.

In the autumn of 2024, Norway was convicted for the first time in the European Court of Human Rights (ECtHR) of violating the right to life (Article 2) of the European Convention on Human Rights. The case concerned an inmate who committed suicide in Oslo prison. The ECtHR concluded that the authorities had not done everything that could reasonably be expected of them to protect the inmate's life.[2] The judgement emphasised, among other things, the lack of cooperation between the health services and the prison. The court judgement was not final as of December 2024.

1 See Sivilombudet (2023) Suicide and attempted suicide in prison.
2 ECtHR Haugen v Norway, complaint no. 59476/21, 15 October 2024, paragraph 153



From a communal section in a prison.
Photo: The Parliamentary Ombud/NPM

› *Deficiencies in both the prison and the healthcare system's follow-up of isolated inmates*

Prisons must work to reduce the harmful effects of both court-ordered solitary confinement and their own decisions on solitary confinement.[3] All inmates who are separated from other inmates shall be offered at least two hours of daily meaningful human contact.[4]

One challenge identified by the NPM is that the activity teams, which are supposed to support isolated inmates, do not always have the capacity to do so. Several activity teams had reduced capacity due to recruitment challenges or sick leave. In Ringerike prison, we found that there was only one person in the activity team several times a week and sometimes no one at all. In Bodø prison, staff told us that when the prison received several inmates on court-ordered isolation simultaneously, they did not manage to follow up everyone sufficiently.

In several prisons, we have also seen that the quality of activities hardly can be said to mitigate the risk of harm due to solitary confinement. Examples of measures registered as "meaningful human contact" by the prisons include spending time alone in the exercise yard or an exercise room, or interact with officers wearing full protective gear. In some prisons, even police interrogations have been recorded as "meaningful human contact". It is unreasonable to assume that such a situation would counteract the risk of harm due to isolation. On the contrary, interrogation could contribute to increased psychological pressure on an inmate in solitary confinement.

Municipal health services also play an essential role in caring for inmates in solitary confinement. Human rights standards stipulate that healthcare professionals should provide assistance to inmates from the moment they are placed in solitary confinement and daily thereafter.[5] This is not always the reality in Norwegian prisons. Our visits have revealed consistent weaknesses in how healthcare departments follow up isolated inmates. In Ringerike prison, for example, we found an inmate who had been completely isolated for several weeks without any documented monitoring by health personnel. We also did not find any assessment indicating that health assistance was unnecessary in this case.

Healthcare professionals should have a free and independent role in prisons, with a particular responsibility to look after patients in situations that could cause them harm. It is of grave concern that municipal health services do not monitor or provide care to isolated inmates more systematically, in accordance with human rights standards.

3 Section 2, third paragraph of the Execution of Sentences Act, cf. Section 1-2, second paragraph and Section 3-35, second paragraph of the Execution of Sentences Regulations. See also the Mandela Rules, Rule 38.2 and the European Prison Rules 53A letters b, f, h and i.

4 The European Prison Rules, Rule 53A a. See also Directorate of the Norwegian Prison and Probation Service, Utarbeidelse av ukeplan for utelukkede innsatte, circular 3/2023

5 Mandela Rules, Rule 46(1); see also European Prison Rules, Rules 43.2-43.3.

From a cell in Stavanger prison.
Photo: The Parliamentary Ombud/NPM

Speaking to prison staff during a visit.
Photo: The Parliamentary Ombud/NPM

Most prison health departments (run by the municipality) only offered services during ordinary working hours from Monday through Friday. They referred to the local emergency health services when they were closed. Consequently, the availability of such services during weekends and in the evenings was variable and fragmented. The limited opening hours contributed to inadequate health care for isolated and new inmates in several prisons.

› *Need to strengthen co-operation between prisons and health services*

The NPM has found significant weaknesses in the organisation of health services for inmates. Overall coordination between the prisons and the health services (municipal and specialist health services) is often weak, especially at middle management level. As a result, healthcare professionals may lack essential information about actual conditions in the prison that affect the inmates' health. Stronger collaboration between the different actors could contribute to an increased focus on public health issues, health-promotion and preventive health measures for inmates, and better guidance for prison officers.

› *Deficiencies in decisions on solitary confinement*

Solitary confinement in prison should only be used in extraordinary cases, as a last resort and for as short of a time as possible.[6] According to the Execution of Sentences Act, the Prison and Probation Service must continuously assess whether there are still grounds for solitary confinement.[7]

Our work has uncovered significant weaknesses in the prisons' decisions to place an inmate in solitary confinement. In Eidsberg prison, for example, decisions were made where it was difficult to understand why ithad been necessary to exclude the inmate. The decisions we reviewed in several prisons also lacked information about which less invasive measures had been considered and why these were considered insufficient. Nor was there any documented assessment of whether the exclusion of the inmate was proportionate.

In several prisons, we found no documented ongoing assessments of whether there were still grounds for the exclusion. For example, an inmate at Ringerike was completely excluded for more than 11 days without any documented assessments, and at

6 Parliamentary Ombudsman, Special Report to the Storting on solitary confinement and lack of human contact in Norwegian prisons, document 4:3 (2018/2019), chapter 4.
7 Execution of Sentences Act, Section 37 (4).

Concerns for inmates at Oslo Prison

In 2024, the NPM carried out a limited investigation of conditions in Oslo Prison after receiving several concerning reports. This investigation built on a previous visit to the prison in 2018, where we uncovered significant challenges with solitary confinement and lock-in regimes in the prison. Six years later, many of the serious challenges seem to persist. Our investigation revealed that, on average, inmates without a work or study placement could be locked up in their cell alone for more than 20.5 hours a day. It is very serious that inmates who have not been placed in solitary confinement by court order or a formal prison decision could be locked up alone in their cells most of the time. The NPM considers the extent of solitary confinement in Oslo Prison constitutes a high risk of violation of the prohibition against inhuman and degrading treatment in Article 3 of the European Convention on Human Rights.

We have asked The Directorate of the Norwegian Prison and Probation Service to provide feedback on what measures are implemented to reduce the extent of solitary confinement in Oslo Prison.

Oslo prison. Photo: The Parliamentary Ombud/NPM

Stavanger prison we found no signs of ongoing assessments in a case where an inmate was excluded from the prison community for 25 days. It is serious that there is no documentation that the prison has carried out regular assessments of whether the conditions for exclusion have been met.

› *Limited use of interpreters*

Our visits have revealed that the prisons made little or no use of interpreters to communicate with inmates who did not speak Norwegian or English. One inmate we met had not engaged in a proper conversation with anyone in the prison for many months due to language barriers. The NPM is concerned about the lack of use of interpreters in prisons in general, and the serious consequences this can have for certain individuals.

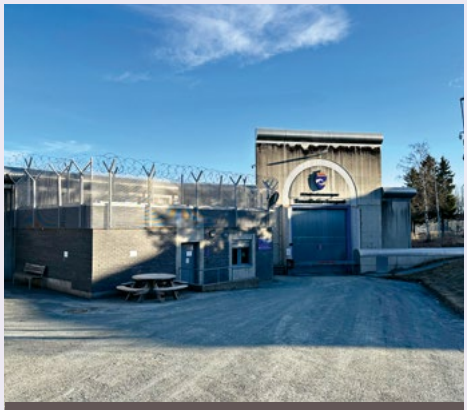
› *Limited opportunities to stay in touch with family and friends*

The ability of inmates to maintain contact with family and friends is, in reality, very limited. Most high-security prisons only allow 30 minutes of phone calls and one hour of visits per week. During our visits, we saw that inmates were not always granted extended phone time, also when this was requested to talk with their children. Other barriers also reduced the opportunity to maintain contact with loved ones. Long distances between the prison and the inmates' home community meant that physical visits were rare, especially for female inmates. The time of day allocated for the use of phones and the cost of calls could also be a barrier. The lack of contact can add a significant burden to inmates and their families, which also can lead to a deterioration of mental health.

Examples from prisons visited:

Trondheim prison, Nermarka Unit: Inadequate sanitary conditions and insecurity among inmates

The prison had two community sections with 20 cells each, in a separate building (E building). None of the cells in the E building had a toilet or shower. During lock-in times, inmates had to call for staff through a calling system to be escorted to the shared toilet. On average, inmates were locked up alone in their cells between 10 and 15 hours a day. Inmates told us that they sometimes had to urinate in the cell's sink, as it could take a long time to be locked out of the cell.



Trondheim prison, Nermarka unit.
Photo: The Parliamentary Ombud/NPM

Halden prison: Inadequate assistance to prisoners in preventive detention

We found seven inmates sentenced to preventive detention in Halden prison. The prison stated that it did not have the resources required to provide for this group in accordance with the regulations. This was also confirmed during the NPM's visit. It is of serious concern that people sentenced to preventive detention, with a potentially indefinite timeframe, do not receive the treatment required for such sentences.

Indre Østfold prison, Eidsberg unit: Inadequate assistance provided to young inmates (18–24 years)

Even though Eidsberg Prison was supposed to have a specialised programme for young inmates, the NPM found significant weaknesses in the follow-up of this group. During the visit, there was only one prison officer in the youth team, and it was unclear how daily tasks were distributed between this team and other prison staff. The support provided to young inmates was inadequate.

Ringerike prison: Increase in long-term exclusions

The number of decisions on long-term exclusion in Ringerike prison almost doubled between 2022 and 2023. Such decision often related to inmates who isolated themselves and inmates with poor mental health and demanding behaviour. The prison faced major challenges in managing inmates with violence and aggression, without resorting to isolation and invasive security measures. The challenging behaviour of inmates was met with security and restrictive measures, which led to increased resistance from inmates. These negative dynamics made it very demanding to work on fostering positive change in behaviour and trust between inmates and prison staff.

Overview of prison visits 2023-2024

Visit report no.	Prison	Visit completed	Report published	Status per 31.12.2024
75	Bredtveit prison and detention centre and Ullersmo prison (Department Zulu East)	March 2023	May 2023	Completed.
77	Halden prison	October 2023	May 2024	Follow-up dialogue with the prison after report. Follow-up dialogue with Halden municipality concluded.
78	Agder prison, Froland unit	November 2023	April 2024	Follow-up dialogue after report.
79	Nordland prison, Bodø unit	November 2023	June 2024	Follow-up dialogue after report.
80	Ringerike prison	February 2024	October 2024	Follow-up dialogue after report. Deadline for first feedback to the NPM 12 February 2025.
81	Trondheim prison and detention centre, Nermarka unit	March 2024	October 2024	Follow-up dialogue after report. Deadline for first feedback to the NPM 10 January 2025.
82	Indre Østfold prison, Eidsberg unit	April 2024	October 2024	Follow-up dialogue after report. Deadline for first feedback to the NPM 16 January 2025.
83	Ålesund prison	September 2024	December 2024	Follow-up dialogue after report. Deadline for first feedback to the NPM 12 March 2025.
84	Stavanger prison	Septem-ber 2024	January 2025	Report in preparation. To be published in January 2025.

Follow-up from the prisons visited

After the visit reports are published, the prisons are given approximately three months to provide written feedback to the NPM on how they are following up our recommendations. In 2024, we received feedback from Bredtveit Prison, Halden Prison, Agder Prison, Froland unit, and Nordland Prison, Bodø unit. The remaining prisons will report to the NPM in 2025.

Bredtveit prison and detention centre

In 2024, we completed the follow-up of Bredtveit high security prison, which we visited in 2023. Although the prison submitted its first feedback in October 2023, the NPM saw a need for more information about the measures implemented after our visit.

In April 2024, we received a new report from the prison, which had been physically relocated to a separate building at Romerike prison, Ullersmo unit. The buildings at Bredtveit high-security prison in Oslo have been closed due to fire safety regulations. This change meant that some of the follow-up points from our original visit no longer were relevant.

In its most recent response to the NPM, the prison provided a more detailed account of how our recommendations have been followed up compared to previous correspondence. Several of the prison's revised procedures now reflect our recommendations. It is also positive that the prison management reports an improved staffing situation, which, among other things, makes it possible to offer staff training and development.

The head of the prison also points out that the new building at Ullersmo unit is more suitable for prison operations than the original premises. It also appears that the prison has worked to strengthen its work on suicide prevention. The NPM finds that Bredtveit Prison has worked to address the reprehensible conditions we found and introduced procedures and systems that reduce the risk of a life-threatening and serious situation like the one we uncovered during our visit in March 2023.

Halden, Froland and Bodø prisons and their health departments have also followed up several of our recommendations. Below are some examples of implemented measures:

Halden prison

- The prison has been allocated four new prison officer positions.
- The prison is running a trial scheme that aims to increase prisoners' phone time from 32 to 42 minutes per week.
- Covered benches have been ordered for the outdoor areas to shield inmates in the prison yard of section A.
- 5 million NOK has been set aside to improve building conditions in the prison's restrictive section.
- The prison is working to strengthen dialogue and collaboration with the health services.

Agder prison, Froland unit

- The prison has increased its use of interpreters.
- The prison has established 6 new work placements for inmates.
- A new role as coordinating legal officer has been established to ensure higher quality in case processing.
- The prison has increased the number of staff managers to give prison officers closer follow-up and guidance in demanding situations.
- The prison has established a collaboration with the Regional Resource Center on Violence, Traumatic Stress, and Suicide Prevention (RVTS) to train and support prison officers in their role.
- The health department and the prison have increased cooperation on topics such as suicide prevention and follow-up of people in solitary confinement.

Nordland prison, Bodø unit.
Photo: The Parliamentary Ombud/NPM

Nordland prison, Bodø unit

- Construction is underway to expand the physical premises allocated for work placements and the activity team.
- Work has been done with operational prison managers to strengthen the quality of decisions made by the prison.
- The prison has requested the remodelling of security cells and is working on revising the instructions for their use.
- A working group has been established between the prison, the municipal prison health services and the specialist health services to strengthen suicide prevention work.
- Increased counselling has been offered to prison officers.
- The prison plans to expand the physical premises of the municipal prison health department.

Resource shortages affect the follow-up of our recommendations

Although several important steps have been taken in these prisons, financial constraints also affect the institutions' ability to follow our recommendations.

Agder prison, Froland unit points out that tight finances have reduced the number of staff working on security and welfare-related issues. The prison expects reduced budgets in the future and notes that this may further affect the number of prison officers.

Nordland prison, Bodø unit points out that both staffing challenges and financial constraints affect the activity programme for inmates.

"Staffing challenges, resources and financial limitations in the Prison and Probation Service contribute greatly to practical challenges in the operation of Nordland Prison, and negatively affects our ability to offer adequate daytime activities to inmates"

(Letter from Nordland prison, Bodø unit to the NPM dated 31 October 2024)

Halden Prison writes that it is challenging to offer inmates a minimum of eight hours outside their cell under the prison's current budget. It is worrying that the prison cannot ensure a minimum of eight hours out of cell every day due to the resource situation.

Halden Prison also reports that the prison's suicide prevention work is negatively affected by the current staffing situation:

"We obviously have a duty to prevent suicide, cf. Article 2 of the ECHR. At the same time, we see that in such cases we also depend on staffing levels that are better than today"

(Letter from Halden Prison to the NPM dated 1 October 2024)

The NPM is seriously concerned that inadequate staffing impairs the prison's ability to protect inmates' lives and health.

Overall, we need more information on how the prisons are working with our recommendations and how current measures are working. We will therefore continue to monitor these prisons in 2025.

Follow-up from the prison health services

The NPM's visits and recommendations have contributed to increased awareness of international minimum standards for health care for inmates and concrete improvements in the prison health services. In 2024, we received information about how the health services in Halden, Froland and Bodø municipalities followed up our recommendations. Below are some of the changes that have taken place in the wake of our visits:

› *Increased cooperation*

Several health departments report that they have strengthened cooperation with other units within their municipality, with the prisons, and with specialist health services following our visits. In Bodø, for example, a working group was set up between the municipality, Nordland Hospital, and the prison, to work on health promotion measures and the prevention of suicide and self-harm.

› *Increased efforts to ensure health screening upon arrival*

Health services that are not present in the evenings, on weekends, or during holidays rarely manage to ensure that all new inmates receive a health assessment, including a suicide risk assessment, within 24 hours of arrival, in line with human rights standards. Several municipalities have nevertheless implemented measures to ensure this happens,

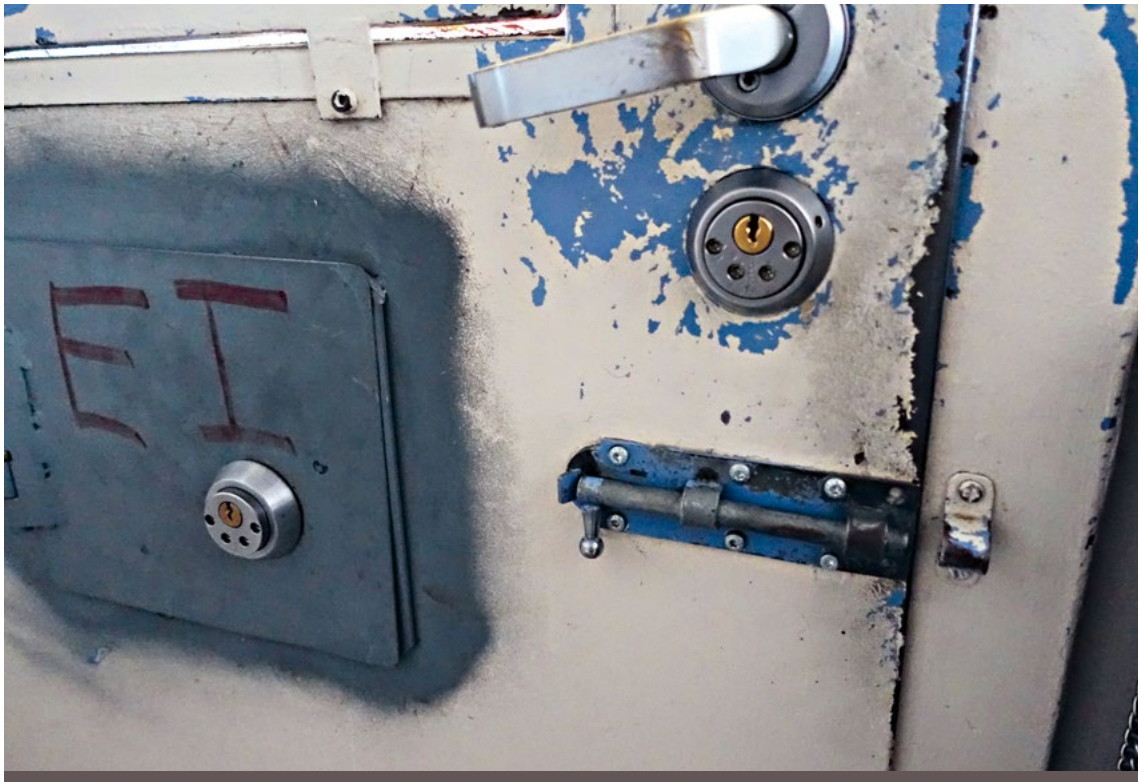


Photo: The Parliamentary Ombud/NPM

in line with the NPM's recommendations. For example, Froland municipality has entered into an agreement with Arendal Accident and Emergency Services, which conducts health checks before admission when the health department is closed.

› *Improved assistance to isolated inmates*

The NPM's visits have increased the awareness of isolation-related harm and need for close health monitoring of isolated prisoners. In Froland, the municipality has introduced a scheme whereby the home nursing service carries out the required health supervision of people in solitary confinement on weekends and public holidays when the health department is closed. In Bodø, internal routines have been changed to ensure that inmates in solitary confinement are followed up by healthcare professionals, regardless of the reason for isolation.

In Halden, measures have also been introduced to ensure daily follow-up of inmates in solitary confinement, with a checklist to ensure thorough and uniform follow-up.

"We appreciate that the Ombud has pointed out these issues. It has allowed us to identify potential for improvement and provide even better health services for inmates in Halden prison."

Therese Orud Schmidt, head of the prison health service in Halden municipality

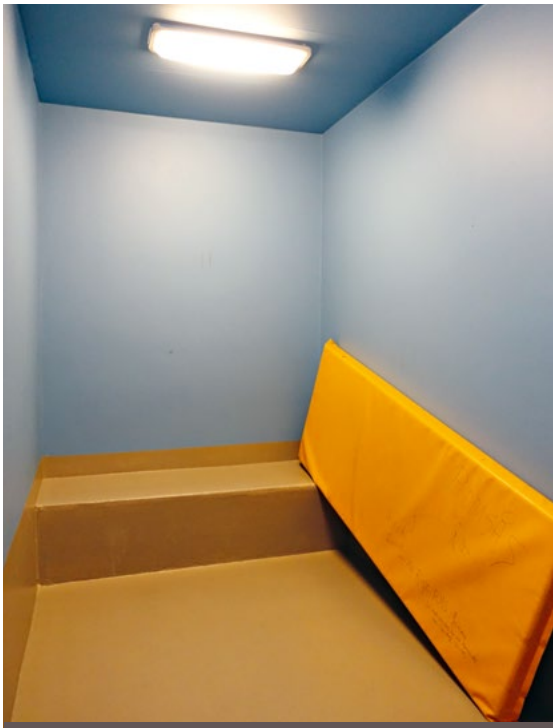
Photo: The Parliamentary Ombud/NPM

Follow-up of Visits from 2022 and 2023

In some cases, the follow-up work requires more extensive communication, and it will take longer for the NPM to close the case. In 2024, we followed up three visits from 2022 and six visits from 2023.

Visit report 76: Holding cells at Oslo District Court

Visit conducted: September 2023
Report published: Februar 2024
Status as of 31.12.24: Follow-up dialogue after report



A holding cell at Oslo District Court.
Photo: The Parliamentary Ombud/NPM

Physical conditions

The holding cells in the district court had an austere appearance, with floors, walls and ceilings made of concrete. There was no furniture in the cell other than a concrete bench to sit on and a plastic mattress on the floor. The cells were located in the basement of the courthouse, and had no windows permitting daylight. One cell was only 4 square metres, and we recommended that the police avoid using it as far as possible. Even though the time spent in these cells usually is short, a lot is at stake for the person brought before the court. The stark design can weaken the individual's ability to prepare their own defence, and we learned that some inmates chose not to attend court hearings because of the distress of sitting in a holding cell.

Coercive measures

All employees in the detention centres carried telescopic batons, handcuffs and pepper spray visible in their belts. The fact that employees carry so many visible tools of coercion can in itself contribute to conflict and increase the likelihood of these tools being used. The NPM questions the practice where

everyone working in the holding cells carries pepper spray, as the risk of inhuman or degrading treatment can be high, particularly when pepper spray is used in enclosed spaces. We also found that the police did not have an adequate overview of the use of force in the holding cells.

We also found weaknesses in the documentation of individual episodes. During one incident, the police used pepper spray, shields, flex cuffs and leg cuffs in the cells. The incident was not described in the custody records, contrary to the requirements of the police's custody instructions.

Lack of supervision

The NPM found that neither national nor local inspections had been conducted in the holding cells at Oslo District Court. Oslo Police District had assumed that the holding cells were not covered by the police district's supervisory responsibility. The NPM challenged this assumption and argued that since Oslo Police District is responsible for operation of the holding cells, it is also responsible for conducting annual inspections of the cells at the District Courthouse. This is in line with existing regulations.

Follow-up of our recommendations

Oslo Police District has implemented several measures following our visit. In October, they informed us that, among other things, they are working to improve the system for custody records. According to the police, this could improve the compliance of the NPM's recommendations, such as better registration of injuries and use of force in the holding cells. A scheme has been established to ensure that inmates can be served a hot meal, and the smallest cell of 4 square metres has now been converted into a storage room.

In the wake of the NPM's recommendations, the National Police Directorate, the Norwegian Courts Administration, and the Oslo Police District have also held a meeting to clarify roles and responsibilities regarding the police use of holding cells in court buildings at a general level. A standard cooperation agreement will be drawn up for all police districts that use holding cells in Norwegian courthouses.

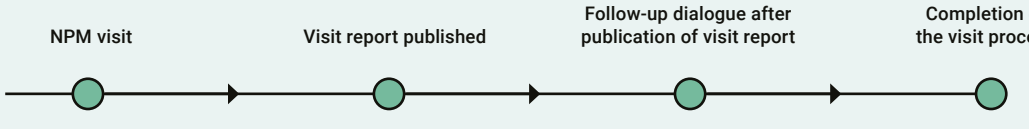
"Regarding the Parliamentary Ombud's remark about the smallest waiting cell, I can inform you that this will no longer be used as a waiting cell but has been converted into a storage room"

(Letter from Oslo Police District to the Parliamentary Ombud, 1 November 2024).

The NPM has asked the police district to submit a new update on the improvement measures by 1 March 2025.

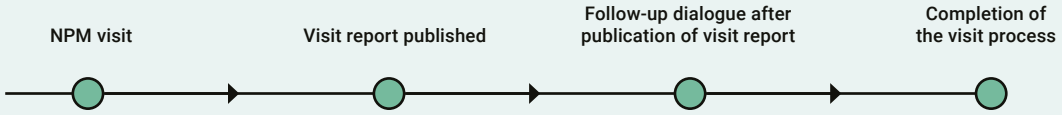
Visit report 72: Humana care and assistance, Kristiansand (child welfare institutions)

Visit conducted: January 2023
Report published: May 2023
Status as of 31.12.24: case closed in April 2024



Visit report 73: Serio Haraldsplass Ung, Agder (child welfare institutions)

Visit conducted: January 2023
Report published: May 2023
Status as of 31.12.24: case closed in June 2024

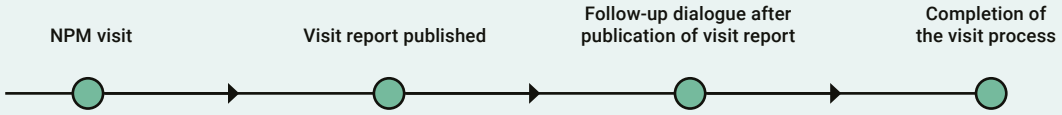


Follow-up of our recommendations for visit report 72 and 73

A key finding from these visits was a lack of awareness of the risk of violence and abuse against children in the institution. We found that this topic was rarely discussed in the staff group and that the idea that colleagues could commit abuse or transgressive acts was alien to many. In the follow-up dialogue with the institutions, we have pointed out that the young people at the institution must be informed about who they can contact if they experience abuse at the institution. Our work has helped raise awareness on the need for such reporting channels, and that these must be known to the institution's residents.

Visit report 70: Regional Secure Psychiatric Unit, St. Olav's Hospital, Østmarka

Visit conducted: September 2022
Report published: February 2023
Status as of 31.12.24: case closed in February 2024



Key findings from the visit:

- Varying quality in decisions on the use of belt fixation.
- Strict and detailed house rules.
- Illegal general ban on the use of private mobile phones, without thorough legal investigation by the Supervisory Commission.

Follow-up of our recommendations

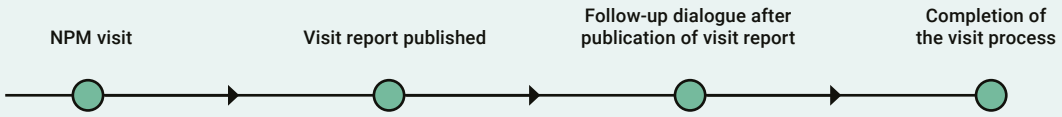
Following our visit report, the hospital has developed an action plan to ensure the follow-up of our recommendations in various levels of the organisation, with regular reporting to the clinic management. Regarding the ban on mobile phones, the hospital initially maintained that all patients are deprived of aphone upon admission, but that they may be allowed to use it following an individual agreement.

The NPM's recommendations were not followed in this case. We therefore asked the hospital to provide new feedback on how they ensure patients' access to private telephones in line with the Mental Health Care Act.

The hospital has since submitted updated "house rules" that give all patients a minimum of 2.5 hours daily access to private mobile phones, tablets and computers. In the NPM's view, the hospital has taken an important step in the right direction. At the same time, the new local rules still allow for a practice in violation of the law, in that patients do not have access to their own phone at the outset. In that vein, we note that regional security units at Oslo University Hospital and Haukeland Hospital give the same patient group much broader access to private mobile phones than the St. Olavs unit. The Norwegian Directorate of Health has also stated that patients at regional security units should have the right to use a mobile phone. The NPM expects that both St. Olavs Hospital and the Supervisory Commission will follow up our feedback and the statement from the Directorate of Health.

Visit report 69: Regional Secure Psychiatric Unit, Oslo University Hospital, Dikemark

Visit conducted: August 2022
Report published: January 2023
Status as of 31.12.24: case closed in May 2024



Key findings from the visit:

- Unsuitable and undignified physical conditions led to an increased risk of coercion.
- Some patients were subjected to both restraints and seclusion for many months at a time.
- We found a lack of documentation on whether the use of fixation belts continued to be "unavoidably necessary" for the entire duration of their use.

Follow-up of our recommendations

The NPM has had an extended dialogue with the hospital about how they are following up on our recommendations throughout 2023. In April 2024, we received a new update from the hospital, which appears to have introduced several measures to reduce the use of coercion, such as regular reviews of all coercion decisions. This seems to contribute to increased awareness of their own practices and enhance a culture of learning. The hospital also appears to have increased training in the Mental Health Care Act following our visit.

In the wake of the NPM's visit, the hospital has been allocated 3.8 million NOK for maintenance work. This has led to the refurbishment of staircases, better soundproofing, lighting, and increased use of communal areas. These are important improvements and in line with the NPM's recommendations. At the same time, some maintenance work remains. The NPM expects that the hospital will carry out the necessary maintenance to create acceptable conditions for patients while waiting for the new security building to open in 2026.

Advisory, Educational and Cooperation Function

Outreach and communication activities are key to the effort to prevent torture and inhuman treatment. In 2024, we met with national authorities, responded to consultations, and spoke at relevant conferences. Below, we present some highlights from the past year.

The Advisory Committee

The NPM's Advisory Committee shall provide expertise, information, advice and input to our work.[1] The Committee consists of both individual members and members representing selected organisations. Members are appointed for two years at a time.

The Advisory Committee met three times in 2024. At the meetings, we discussed, among other things, findings from our visits to prisons and the follow-up of conditions at Østfold Hospital.

When necessary, meetings are also organised with individual members of the Advisory Committee to obtain input on specific topics we are working on. In the past year, we received useful input from the Organisation for Families and Friends of Prisoners (FFP) to our work on inmates' opportunities for contact with the outside world.

From one of the meetings in the Advisory Committee. Photo: The Parliamentary Ombud/NPM

1 Section 19 of the Parliamentary Ombudsman Act stipulates that there shall be a dedicated advisory committee for the national preventive mechanism.

Members of the Advisory Committee 2024:

- **Amnesty International Norway**
- **Equality and Anti-Discrimination Ombud**
- **Human Rights Committee of the Norwegian Medical Association**
- **Human Rights Committee of the Norwegian Psychological Association**
- **Jussbuss (free legal aid clinic run by law students)**
- **Norwegian Alliance for Informal Carers**
- **Norwegian Association for Persons with Intellectual Disabilities (NFU)**
- **Norwegian Bar Association**
- **Norwegian National Human Rights Institution (NIM)**
- **Norwegian Red Cross**
- **The Ombudsperson for Children**
- **The Organisation for Families and Friends of Prisoners (FFP)**
- **WayBack**
- **We Shall Overcome National Association**
- **Youth Mental Health Norway**
- **Nora Sveaas**, Professor Emerita, University of Oslo, former member of the UN Committee against Torture (CAT) 2005–2013 and former member of the UN Subcommittee on the Prevention of Torture (SPT) 2014–2018.
- **Georg Høyer**, Professor Emeritus, University of Tromsø, member of the European Committee for the Prevention of Torture (CPT) 2012–2022.
- **Asbjørn Rachlew**, Police Superintendent and researcher, Norwegian Police University College and the Norwegian Centre for Human Rights, member of the European Committee on the Prevention of Torture (CPT) since 2022

NPM staff members lecturing at the University College of Norwegian Correctional Service.
Photo: University College of Norwegian Correctional Service

Prison

Our prioritisation of the prison sector is also reflected in our outreach work in 2024. In the past year, we have worked actively to disseminate knowledge about our findings and recommendations to various organisations that work in or with the correctional services. For instance, we presented our findings on suicide in prison at the annual conference of the Norwegian Association for Criminal Reform (KROM). We also provided the Ministry of Justice and Public Security with input to a new white paper about the correctional services. In addition, we have presented relevant findings to the Committee on Criminal Justice Sanctions and Mental Health.

The NPM has also shared our knowledge with Red Cross volunteers and the Jussbuss (free legal aid) prison group, amongst others. As in the past, we have also held regular lectures for students at the University College of Norwegian Correctional Service (KRUS). We have also given a lecture on prison conditions to the Supreme Court of Norway.

Dialogue about the inspectorate system for the correctional services

In 2023, the Norwegian Parliament decided to establish a new prison inspectorate in Norway. This new system will come into force on 1 January 2025 and will be managed by the Norwegian Civil Affairs Authority (SRF). In 2024, the NPM provided input to the SRF, in addition to existing and incoming appointed leaders of the inspectorate. We have shared information about our methodology and issues that we believe the inspectorate should pay particular attention to.

Healthcare services for inmates

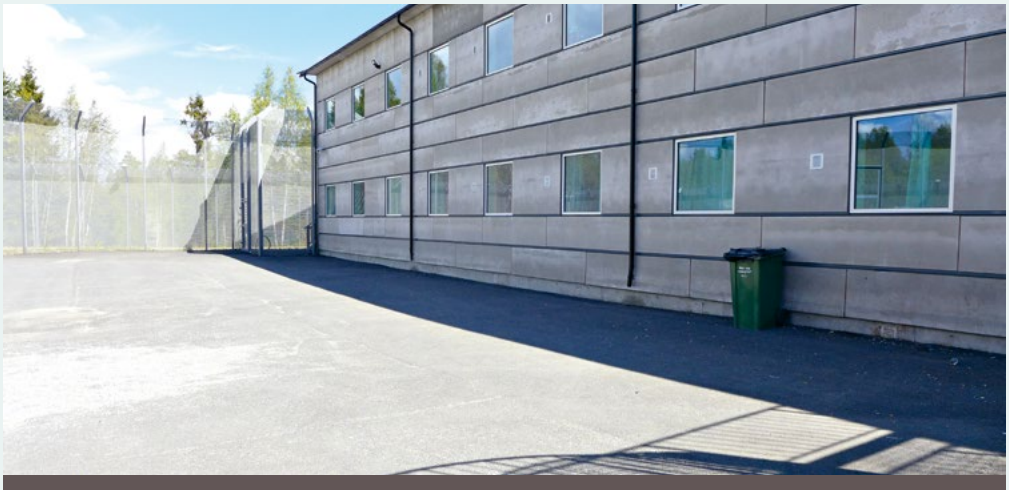
Our visits have uncovered several weaknesses in the healthcare services for inmates, and it has been important for us to communicate this to relevant bodies in both the justice and health sectors. In 2024, we co-organised a seminar on health services for prisoners together with the Norwegian Medical Association. We also contributed to a workshop on suicide prevention in prisons, organised by the Norwegian Directorate of Health. Participants included the Directorate of Correctional Services and heads of municipal prison health services. We have also presented our findings at the annual course on health law organised by the The Center for Continuing Legal Education.

The Police Immigration Detention Centre at Trandum

The NPM has over several years expressed concern about the conditions for detainees at the Police Immigration Detention centre at Trandum, the only one of its kind in Norway. There is an immediate need for change at the centre, which relates among other things to the practice of locking up detainees in their cells. The NPM deems the current practice as illegal. Furthermore, detainees at the centre do not have access to their mobile phones, although we cannot see that the Immigration Act provides a legal basis for such restrictions. The Supervisory Board for Forced Returns and Immigration Detention has expressed concern about several of the same conditions for years.

The Ministry of Justice and Public Security has informed the NPM several times that a revision of the Immigration Detention Centre Regulations is underway. The National Police Directorate sent proposed amendments to the regulations to the Ministry on 28 May 2021. The Ministry informed the NPM that it would be working on an amendment proposal in autumn 2021.[1] In a new briefing in March 2022, the Ministry apologised and informed us that this work was delayed.[2] In August 2023, the Ministry informed that a consultation paper on amendments to the Immigration Act and the Immigration Detention Centre Regulations would be submitted for consultation around the turn of 2023-2024. [3] At the end of 2024, this has still not happened.

It is disappointing that the work on new immigration detention centre regulations is taking so long. Changes are needed to ensure that the treatment of detainees is in line with the state's human rights obligations.



The Police Immigration Detention Centre at Trandum. Photo: The Parliamentary Ombud/NPM

1 See the Ministry of Justice and Public Security letter to the Ombud, dated 23 August 2021.
2 See letter from the Ministry of Justice and Public Security to the Ombud, dated 15 March 2022
3 See letter from the Ministry of Justice and Public Security to the Ombud, dated 12 September 2023

Other sectors

In 2024, we continued sharing our insights and findings from previous visits to child welfare institutions, mental health care hospitals, nursing homes and homes for people with intellectual disabilities, even though these are sectors we have not visited this year. For instance, in the autumn we lectured for learning disability nursing students at Østfold University College and held a lecture for psychology students at the University of Oslo. We have also provided input to the Norwegian Board of Health Supervision's work to establish an investigation unit for very serious incidents involving children. In addition, we have shared our experiences with the governmental expert group that will assess measures for children who commit serious or repeated offences.

Follow-up of findings from homes for people with intellectual disabilities

It is important to note that other supervisory bodies also follow up and explore issues that we have raised in previous visits. In 2024, the Norwegian Board of Health Supervision published findings from a national project on coercion towards people with intellectual disabilities. The report shows, among other things, that there is great variation in how the County Governors review decisions of coercion under Chapter 9 of the Health and Care Services Act. It also shows that limited capacity at the County Governor's offices can jeopardise legal protection for people with intellectual disabilities. The report confirms our previous findings from visits to this sector. It is positive that the Norwegian Board of Health Supervision proposes concrete measures to improve the situation.

Consultation response – revised Police Custody Instructions

In 2024, the NPM submitted a consultation response to the revised Police Custody Instructions. One of the purposes of the revision was to follow up on criticism made by bodies such as the Parliamentary Ombud and the NPM. We were in favour of several of the proposed changes, such as the minimum requirement of at least two officers in the custody facility, more detailed requirements on how to keep custody records, and stricter requirements for conducting body searches. We also made several suggestions for the new instructions, such as recommending:

- that it should be specified what proportion of the cells should have a more ordinary design
- that there should be clearer guidelines for the cells that can be used for minors
- that the use of pepper spray inside police custody cells should be banned or clearly restricted

International cooperation

94 states are parties to the UN's Optional Protocol against Torture (OPCAT). Globally, there are 79 NPMs. International exchanges and dialogue contributes to mutual capacity building and is important for developing the preventive mechanisms.

In the past year, we have initiated dialogue with other NPMs and been invited to support the work of others. We have hosted study visits from the NPM in Lithuania and the Czech Republic. Furthermore, we have engaged in valuable dialogue with the NPM in the UK and the Netherlands. The opportunity to learn about other NPM's practices has proven very useful. In the autumn, we participated in the annual Nordic NPM meeting, organised in Helsinki. The theme of this year's meeting was health services for prisoners.

The Norwegian NPM visiting Dignity – Danish Institute Against Torture.
Photo: The Parliamentary Ombud/NPM

In August, the NPM travelled to Copenhagen and Malmö, to learn more about rehabilitation of torture victims. Two from The Norwegian Medical Association human rights committee members also took part. Together we had inspiring meetings with:

- Danish Parliamentary Ombudsman
- Dignity – Danish Institute Against Torture
- IRCT – International Rehabilitation Council for Torture Victims
- Swedish Red Cross treatment centre for torture victims in Malmö

Visit from the European Committee for the Prevention of Torture

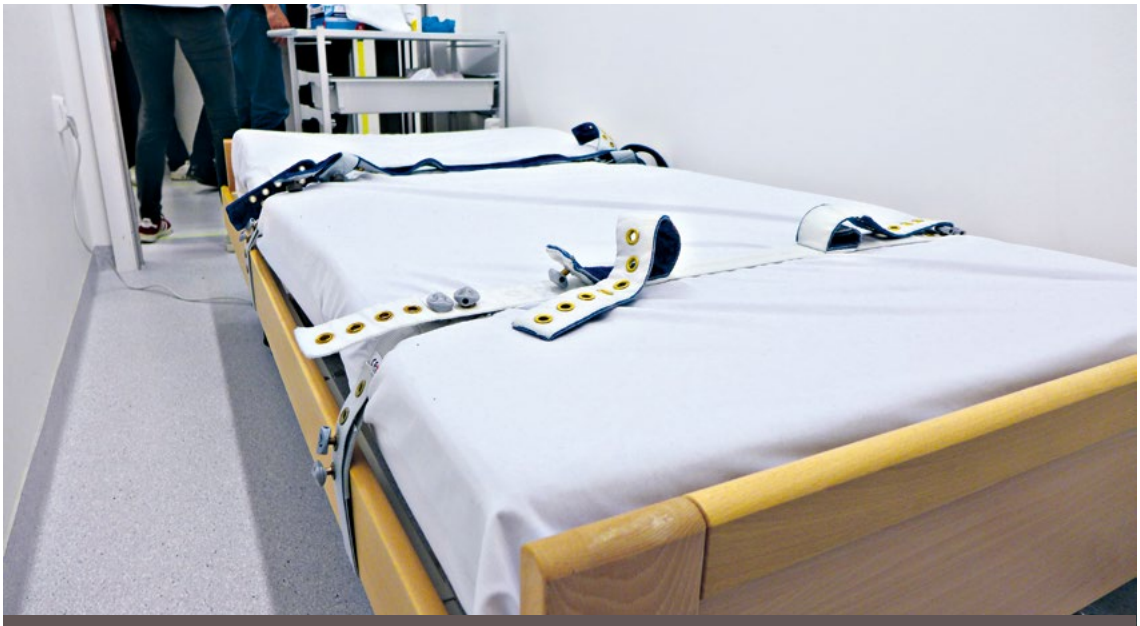
In May 2024, a delegation from the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) came to Norway for its sixth periodic visit. The NPM contributed to the visit by briefing the delegation on various risk areas. We were invited by the authorities to participate in the committee's summary meeting with the Ministry of Justice and Public Security and the Ministry of Health and Care Services. The final report from the visit was submitted to the Norwegian authorities at the end of 2024 and published in January 2025. [1]

The CPT made several recommendations related to prisons, noting that budgetary and staffing pressures affect inmates and staff conditions. Like the NPM, the CPT has also expressed serious concern about prolonged belt fixations at Østfold Hospital. The Committee notes that this may constitute inhuman or degrading treatment. The CPT also points to the need to reduce the extent of confinement and offer more activities to detainees at the police immigration detention centre, Trandum. The CPT's work, assessments and recommendations are an important reference point for the NPM's ongoing work.

1 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 21 to 31 May 2024 CPT/Inf(2025)03: https://rm.coe.int/1680b37399

The Parliamentary Ombud meets the delegation from the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) in May 2024. Photo: The Parliamentary Ombud/NPM

Concerns About Prolonged Belt Fixation at Østfold Hospital



A restraint bed at Østfold Hospital. Photo: The Parliamentary Ombud/NPM

Background

In the autumn of 2023, the NPM received concerning reports of the prolonged restraint of a patient at one of the two local secure psychiatric wards at Østfold Hospital. The patient in question had been fixated to a bed with belts continuously for almost 41 days (982 hours). We were also made aware of another case in which a patient was allegedly restrained for approximately six weeks while admitted to the other secure psychiatric ward at the hospital.

The NPM visited these two wards in 2018 and criticised the hospital for the prolonged use of restraints over several days, without documented assessments of whether the conditions for use had been met all the time. Due to the severity of the incoming reports, as well as our previous concerns, we asked for extensive documentation related to one of the patients and an overview of the hospital's regulations and procedure regarding the use of restraint measures.

What did we find?

The documentation we received increased our concern that patients at the hospital were being placed in belts also when legal requirements for

such treatment were not present. We also found that the Supervisory Commission visiting the hospital did not problematise such use of coercion.

In our review of the patient's medical records, we found almost no documented assessments of whether and why it was considered absolutely necessary to continue to keep the patient in belts. Such assessments appeared to have only been discussed in weekly conversations between the therapist and the patient. During this period, the patient was continuously restrained to the bed against the patient's will. This is unacceptable.

The document review also revealed that the restraint caused the patient significant pain and humiliation. The hospital was unable to show that this had been considered as part of the requirement that the use of force must be proportionate. After a short time in the restraint bed, the patient developed problems with urination and defecation, and these challenges persisted for much of the almost 41 days that the restraint lasted.

Our review also showed that the Hospital's Supervisory Commission had failed to fulfil its duties. The Commission's answers to our questions did not provide assurance that thorough and specific assessments had been made of the patient's situation. The Commission had not examined whether the conditions had been met throughout the entire restraint period.

A comparison of restraints nationally showed that Østfold Hospital's security sections were an outlier compared to other similar wards, with several particularly long restraints. Our investigation makes the NPM very concerned that prolonged belt fixation has become a normalised practice at the hospital.

What did we do?

In April 2024, we sent letters to Østfold Hospital and the local Supervisory Commission. The letters contained detailed accounts of the NPM's concerns in the specific case where we also referred to several examples from the patient's medical records to concretise our concern.

The letters posed several questions to both the hospital and the Supervisory Commission. The response from the two bodies did not reassure the NPM about the situation for the specific patient, the use of mechanical restraints in the secure wards, or the Supervisory Commission's oversight of the legal protection of patients subjected to long-term restraint measures.

Therefore, in June 2024, a new letter was sent to the hospital requesting a meeting with its management. The letter stated clearly that the NPM considered there to be a high risk that the prohibition against inhuman and degrading treatment in Article 3 of the European Convention on Human Rights (ECHR) had been violated in this specific case. The meeting with, among others, the hospital's chairman and director was held on 21 June 2024.

What has the hospital done since the concerns were reported?

Following the meeting, the hospital has provided a written account of the immediate measures implemented and submitted an action plan for further follow-up. The NPM has requested an updated account of the measures that have been implemented and the preliminary outcome of these measures, including findings from an internal audit, by 1 February 2025.

Who else has been notified?

Because we consider the case to be very serious, the NPM has notified the County Governor and the Board of Health Supervision of the case. We have reminded them of the state's duty to investigate when there are sufficiently clear indications that a violation of Article 3 of the ECHR has taken place. We have asked the County Governor and the Board of Health Supervision to inform the NPM on how they will follow up on the case by 31 December 2024.

Children in Eidsberg Prison

Background

Since 2020, Eidsberg Prison, a high-security prison for male adults, has been required to accept up to three minor inmates (under 18 years old). During our visit to the prison, two children were placed in the prison alongside the adult inmates. Based on the serious findings, we conducted a separate investigation into the three placements for minors in the prison and the extent to which minors are also placed in other adult prisons. The report was published at the beginning of June.

What did we find?

Since Eidsberg Prison was given the task of receiving up to three underage inmates, it has received extra funding to have a youth team to look after the children. The youth team was originally supposed to consist of five or six employees, but during our visit, there was only one prison officer on the team. He did not have the capacity to supervise the minors on his own.

Although it follows directly from the UN Convention on the Rights of the Child that children should not be imprisoned with adults unless it is in the best interests of the child, the minors were placed in communal sections with eleven adult inmates. At times, they were also alone in the section with adult inmates, without staff members present.

We investigated the cases of the ten minors who had been in Eidsberg prison in 2024, and found that no specific assessment was made of whether the placement in an adult prison was in the best interests of the child. In several cases, the District Court, which decided on the pre-trial detention, was misinformed about the conditions in the prison. The Norwegian Correctional Service's Regional Office, which allocated places in the prison when the juvenile prison units were full, had no routine for assessing the best interests of the child.

We also requested an overview from the Directorate of Correctional Services on how many children had been placed in adult prisons in 2023 and from January to May 2024. We found that several prisons had been used to place minors, even though they had no particular programme for receiving minors.

What did we do?

We sent our report to the Ministry of Justice and Public Security. The report recommended that the practice of placing children in Eidsberg prison should cease immediately, and that measures should be implemented without delay to ensure that minors were not placed in adult prisons unless it was deemed to be in the best interests of the child.

Follow-up of our recommendations

In the Ministry's reply to us of 23 September 2024, they stated that it was a goal that minors should not be placed together with adults in prison unless it is in the best interests of the child. The Ministry also wrote that the Directorate of Correctional Services had signalled that there would not be enough capacity inthe juvenile units in 2025 and 2026, and that the Ministry would return to this when the national budget was presented. When the state budget was presented, 145 NOK million was set aside to establish a new youth unit, and it has since become clear that the prison in Evje will be rebuilt and become a new youth prison unit with eleven places.

Budget and Accounts for 2024

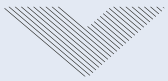
Category	Budget 2024	Accounts 2024
Salaries	10 835 000	10 644 214
Operating expenses		
Production and printing of visit reports, annual report and information material	280 000	137 615
Purchase of external services	315 000	481 208
Travel (visits and meetings)	905 000	508 112
Other operating expenses	435 000	361 794
Share of the Parliamentary Ombudsman's joint expenses (incl. rent, electricity, IT services, security, cleaning etc.)	2 550 000	2 531 396
Total NOK	**15 320 000**	**14 664 339**

Photo: Scott Graham, Unsplash.

How a NPM visit is carried out

Prepare for the visit and gather information

Conduct the visit

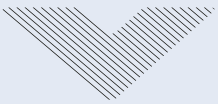


Write a report

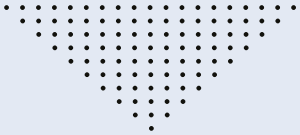
Publish the report with findings and recommendations

The place of detention follows up the recommendations in the report

The place of detention gives feedback to the NPM regarding the follow-up of findings and recommendations



The NPM makes an assessment of the feedback from the place of detention. Renewed dialogue if necessary



Closing the case

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