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**The Norwegian NPM's submission to the UN Committee Against Torture's
85th session from 16 November to 4 December 2026 - Information regarding
the Norwegian Government's implementation of the Convention**

Reference is made to the letter of 12 August 2026 on behalf of the Committee against Torture. The Parliamentary Ombud would like to thank the Committee against Torture for the opportunity to provide information regarding the Norwegian government's implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The issues highlighted in this report is based on the Norwegian NPM's visits to places of detention during the period 2018-2026. The report summarises the NPM's main findings and concerns but is not intended to be an exhaustive report. A full account of the NPM's findings after each visit can be [found at our webpage](#).

The Norwegian NPM remains at the Committee's disposal for future cooperation and assistance.

On behalf of the Parliamentary Ombud in Norway

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This letter has been electronically approved and has no handwritten signature.

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1. The Parliamentary Ombud's tasks as the National Preventive Mechanism in Norway

On 21 June 2013, the Norwegian Parliament (Stortinget) decided that Norway would ratify the Optional Protocol to the Convention against Torture (OPCAT). The Parliamentary Ombud was assigned the task of exercising the mandate set out in the OPCAT. The Parliamentary Ombud's Act was amended by Parliament to ensure that the Ombud could discharge its mandate as NPM in accordance with the requirements of the OPCAT. Based on this mandate, the Parliamentary Ombud established a dedicated national preventive mechanism at its office in 2014. In 2021, the Storting adopted a new Act concerning the Parliamentary Ombud for Public Administration. Pursuant to this Act, the institution formerly known as the Parliamentary Ombudsman was renamed the Parliamentary Ombud for the Scrutiny of Public Administration (Parliamentary Ombud). The change was made to ensure that the title was gender neutral. The new law includes a separate chapter incorporating the relevant OPCAT articles pertaining to the functioning as NPM.

The NPM is organised as a separate department at the Ombud, and it does not consider individual complaints. Under its preventive mandate, the NPM has a right to visit all places where somebody are, or may be, deprived of their liberty. This includes public and private institutions and all other places of detention in Norway, including places abroad where the Norwegian government exercises jurisdiction. Based on these visits, the NPM issues recommendations for the purpose of preventing torture and other cruel, inhuman or degrading treatment or punishment.

All the NPM's reports and recommendations following visits are publicly available and published on the Ombud's website. The places visited are requested to provide an account to the NPM of how the recommendations have been followed up within a few months. These accounts are also published.

The NPM has an interdisciplinary composition, and its employees have degrees in the fields of law, sociology, psychology, social science and human rights. The NPM also has the possibility to call in external experts for individual visits, such as medical expertise. By the end of the year, the NPM will consist of twelve staff members, including the head of department.¹

2. Prisons

Reference is made to CAT articles 2 and 16; The Committee's list of issues para 4 a)-d), 16-19, The State party's report paras. 122-149, 153-155 and the Committee's Concluding Observations 2018, para 18 a-h.

2.1 Overview

During 2018-2026, the NPM has undertaken 19 visits to high-security prisons. Visits included several prisons that may incarcerate women and one of the prison-visits included a unit with a particularly high security level. Visits have also been made to two out of three prisons for juvenile offenders. Since 2018, the NPM has published eight thematic reports based on visits to prisons, and two special reports to the Norwegian Parliament:

¹ From its establishment in 2014 to early 2016, the unit's staff comprised of 4.5 full-time equivalents, including the head of department. Since then, the number of staff has increased.

- [Special report to the Storting on solitary confinement and lack of human contact in Norwegian prisons \(2019\)](#)
- [The Use of Restraint Beds in Norwegian Prisons \(2020\)](#)
- [Protecting prison inmates during the COVID-10 pandemic \(2020\)](#)
- [Suicides and Suicide Attempts in Norwegian Prisons \(2022\)](#)
- [Prisoners' Access to Contact with Family and Friends \(2025\)](#)
- [The Use of Interpreters in Norwegian Prisons \(2025\)](#)
- [Security Cells in Norwegian Prisons \(2025\)](#)
- [Special report to the Storting on extensive cell confinement and de facto isolation in Norwegian prisons \(2025\)](#)
- [Healthcare Services for Prisoners \(2026\)](#)
- [Children Placed in Security Cells and Restraint Beds in Norwegian Prisons, 2016–2025 \(2026\)](#)

2.2 Extensive cell confinement and de facto isolation

In 2019, [in a special report to the Norwegian Parliament](#), the NPM alerted the Storting about the extensive use of solitary confinement and the lack of meaningful human contact in Norwegian prisons.² On 22 April 2020, the Storting unanimously called on the government to implement measures and legislative amendments to follow up the recommendations.³ This led to the launch of several initiatives by central authorities. Despite these efforts, the Parliamentary Ombud has, since 2019, received numerous concerns from inmates, staff, and family members about the prison conditions. In 2023–2024, we therefore conducted new NPM-visits to ten high-security prisons. These investigations indicated that the authorities had not succeeded in reducing extensive confinement.

Based on these concerns, the NPM in early 2025 submitted [a new special report to the Storting](#) on extensive cell confinement and de facto isolation. The findings show that an increasing proportion of prisoners spent less than eight hours per day outside their cells. Although some prisoners subject to formal solitary confinement decisions receive improved follow-up, many remain locked in for prolonged periods due to general prison conditions. For several prisoners, this amounts in practice to de facto isolation.⁴

In 2026, a legislative amendment was made in the Execution of Sentences Act, with the aim of reducing the use of isolation in prisons.⁵ However, due to the lack of financing and staffing, the bill is not yet in force, and it remains unclear when it will be implemented. When in force, the law will establish that prisoners should be guaranteed daily access to association with other prisoners, and that time spent outside the cell should normally amount to eight hours or more per day. However, the law still permits excessive confinement. Prisons would be able to keep prisoners locked in their cells for up to 20 hours a day without any formal decision or individual assessment. Such extensive

² Almost all cells in Norwegian high-security prisons are single-occupancy cells. As such, when we refer to extensive cell confinement in prisons in a Norwegian context, this also entails isolation from other inmates and prison staff.

³ Recommendation 172 S (2019-2020). Decision in accordance with recommendation.

⁴ De facto isolation refers to situations where inmates are locked in for most of the day without disciplinary reasons or formal decisions.

⁵ Proposition 165 L (2024-2025) concerning amendments to the Norwegian Execution of Sentences Act.

confinement is often harmful to health. By comparison, prisoners in Sweden and Denmark are entitled to substantially more time out of their cells than eight hours per day.

In conclusion, The NPM is highly concerned that the conditions in Norwegian high-security prisons are deteriorating further. We have found that some prisons systematically violate the existing legal provisions on exclusion from company (e.g. isolation), due to a combination of persistent staffing shortages and unsuitable physical premises. In 2025-2026 the NPM raised these matters with the Directorate of the Correctional Services and later the Ministry of Justice. While these authorities provided information on various measures to bring the systematic violations of the legal framework to an end, we remain highly concerned about the current situation. The seriousness of the situation means that the Ombud will closely monitor developments in the high-security prisons going forward.

The State party should:

- **ensure that all prisoners have a statutory right to spend at least eight hours each day engaged in meaningful human contact, social interaction and activities outside their cells.**
- **as a matter of urgency, take all necessary steps to ensure that prisoners are not subjected to extensive cell confinement or de facto isolation as a result of infrastructure or persistent staffing shortages.**

2.3 Coercive measures

2.3.1 The use of security cells

Solitary confinement in a security cell is among the most intrusive measures that can be used against prisoners.⁶ Based on findings from visits to 13 high-security prisons from 2023 to 2024, the NPM published a [thematic report on the use of security cells in prisons](#). One of the main findings is that the physical design of security cells in itself entails a risk of violating the prohibition against inhuman or degrading treatment. Security cells are bare concrete cells with smooth walls, a plastic mattress and a toilet consisting of a hole in the floor. Most cells have a door with a hatch near the floor, a hatch at chest or waist height, and an inspection window. The design of the cell provides extremely limited sensory stimulation and significantly restricts the prisoner's ability to meet basic personal needs. The physical design of security cells in juvenile units have largely the same degrading characteristics.

At a minimum, security cells should provide access to daylight, opportunities for sanitation, hygiene, water and food in a dignified and humane manner, and a physical design that reduces the risk of disorientation and isolation-related harm. In its follow-up of the thematic report, The Ombud notes that the Ministry of Justice and Public Security and the Norwegian Correctional Service have implemented several measures to modify the physical design of security cells, and that additional measures are under consideration. However, most security cells are situated in older buildings, where carrying out substantial alterations may prove challenging. In the Ombud's view, it is crucial that security cells be designed in a way that respects prisoners' fundamental needs and dignity. The current standard still fails to meet this requirement.⁷

⁶ See Section 38, first and third paragraphs, of the Norwegian Execution of Sentences Act.

⁷ The Parliamentary Ombud's letter to the Ministry of Justice and Public Security, concerning The Ministry of Justice and Public Security's follow-up of the thematic report on security cells, 13 May 2026.

Our findings also show that many prisoners remain in security cells longer than permitted by law. Although prisons are required to continuously assess whether the grounds for placement in a security cell still exist, they too rarely consider whether the placement can be terminated, and the reasons provided are often highly inadequate. Minimum standards should be established for prisons' assessments and documentation of ongoing reviews in order to prevent placements in security cells from lasting longer than strictly necessary.

The State party should:

- **take immediate action to alter the physical conditions of all security cells, including in juvenile units, and strengthen procedural safeguards governing their use.**

2.3.2 The use of security cells in the event of acute suicide risk

In many of the prisons visited, security cells were used to manage self-harm and suicide risk. In four prisons, between 70 and 80 per cent of the reviewed security cell decisions were justified by suicide attempts, self-harm or expressed intentions to take one's own life. Placing a person who has just attempted suicide alone in a bare concrete cell is highly problematic and may intensify feelings of despair. The case law of the European Court of Human Rights (ECtHR) shows that isolating suicidal prisoners in security cells may constitute a breach of the prohibition against inhuman or degrading treatment. Following its visit to Norway in 2024, the European Committee for the Prevention of Torture (CPT) criticised Norwegian prisons for responding to self-harm by using solitary confinement and security cells. The Committee pointed out that prisoners experienced this as punitive and emphasised that self-harm often reflects mental health needs that should be met with increased health care. Several prisoners interviewed by the NPM reported that they refrain from speaking about distress or suicidal thoughts because they fear being placed in a security cell. This may hinder open dialogue with prisoners in crisis and contribute to loss of life. This is particularly problematic given the high rate of suicides and suicide attempts in Norwegian prisons.

In its follow-up of the thematic report on security cells, the Ministry emphasises that the need to prevent serious self-harm and suicide is a relevant consideration in the design and furnishing of security cells. It particularly refers to the Norwegian Correctional Service's experience that, in certain situations, the use of a security cell is indispensable as an emergency measure to prevent a prisoner from causing serious harm to themselves or taking their own life. The Ombud question this position and reiterates that the highly intrusive form of isolation and sensory deprivation resulting from the design of current security cells may, on the contrary, increase the risk of suicide. In addition, placing a prisoner in a security cell will normally involve the mobilisation of a significant number of staff to carry out the transfer. In the acute situations described by the Ministry, consideration should be given to how these staff resources can be used in a manner that does not deprive the prisoner of human contact while awaiting the arrival of healthcare personnel.⁸

The State party should:

- **as a matter of urgency, discontinue the use of isolation for the purpose of preventing self-harm or suicide attempts. If retained, such measures should be strictly limited to emergency situations involving an immediate risk of harm, applied for the shortest time**

⁸ See The Parliamentary Ombud's letter to the Ministry of Justice and Public Security, concerning The Ministry of Justice and Public Security's follow-up of the thematic report on security cells, 13 May 2026.

possible and with immediate presence of personnel ensuring continual human support, and regulated by a specific legal framework incorporating robust procedural safeguards and independent oversight.⁹

2.3.3 Children in security cells

In the spring of 2025, the NPM visited the [juvenile unit at Bjørgvin Prison](#) and examined the use of security cells over a 15-month period. Our findings indicated that there was a substantial risk that children were subjected to unlawful placements in security cells, as well as treatment that may be incompatible with the prohibition of inhuman or degrading treatment.

Following this visit, the NPM decided to review all decisions concerning the use of security cells and restraint beds on children in all Norwegian prisons during the period 2016-2025. The findings of this review, which was published in a [thematic report](#), confirmed our concern that, over many years, the Correctional Service had frequently applied a lower threshold for the use of coercive measures against children than is permitted by law. Several dozens of children had, thus, been illegally placed in solitary confinement in security cells. The review also uncovered serious deficiencies in the obligation to consider less restrictive alternatives and to assess the proportionality of each individual placement of a child in a security cell. Furthermore, the report revealed a longstanding lack of adequate oversight of the most intrusive coercive measures available to the Correctional Service in its treatment of children. It is deeply concerning that such extensive errors, with such serious consequences for children, have been allowed to persist for so many years. The Ombud has received the Ministry's response regarding the implementation of the report's recommendations. However, the case remains under considerations, pending further responses from the Ministry.

The State party should:

- **ensure that security cells are used against children only as a measure of last resort, for the shortest possible period of time, and in strict compliance with domestic law and international human rights standards.**
- **systematically collect, publish and monitor disaggregated data on the use of coercive measures against children in places of detention, in order to strengthen transparency, accountability and oversight.**

2.3.4 Restraint bed in prison

The use of restraint beds was one of the main concerns highlighted by the NPM to the List of issues prior to reporting (LOIPR). A restraint bed is considered the most intrusive coercive measure available to the Norwegian Correctional Service. In 2020, the Ombud [published a thematic report](#) which examined the use of restraint beds in Norwegian prisons and recommended that restraint beds should be abolished. This is in line with the recommendation made by CPT during its visit to Norway in 2018 and 2024.¹⁰ The use of mechanical restraints can pose a considerable risk of both physical and psychological injury. It is a major violation on personal integrity, and creates a risk of somatic injuries, trauma, and other negative consequences to mental health. A disproportionate 30 per cent of cases of

⁹ In connection with the amendment of the Execution of Sentences Act in 2026, a petition resolution was adopted that requested the government to ensure that guidelines are issued clarifying that the use of security cells in prisons to prevent suicide and self-harm may only be employed as an emergency measure to avert imminent harm, for short periods of time and subject to strict safeguards.

¹⁰ See CPT/Inf (2019) 1, paragraph 107 and 111 and CPT/Inf (2025), paragraph 135.

inmates being placed in restraints in the period investigated, concerned women (approximately 6 per cent of inmates are women). This included some of the longest periods spent in restraints.

In 2021, the Directorate of the Correctional Service decided that the use of restraint beds as a coercive measure within the correctional services should be phased out over time. However, in 2026, the Ministry still maintains that the legal authority to use restraint beds should be retained in the Execution of Sentences Act until the necessary prerequisites for a safe phase-out have been established. According to the Ministry, these prerequisites are not currently in place.¹¹ The Ombud is concerned that there has been a shift from a policy of phasing out restraint beds in 2021 to retaining them as a measure of last resort.

The State party should:

- **intensify its efforts to abolish the use of restraint beds in prison.**

2.3.5 Spit hoods

The use of spit hoods is a highly intrusive measure. It carries safety risks and may cause significant distress, anxiety and feelings of panic. In 2021, legislative amendments were made to the Execution of Sentences Act article 38 (use of coercive measures), to allow the use of spit hoods in prison. The NPM has expressed criticism of the practice. Spit hoods are by necessity applied in combination with other restraint devices to hinder the inmate from removing the hood. CPT has advised against the use of similar equipment designed to prevent spitting, particularly when used in combination with other coercive measures.¹² Used in this way, it carries a risk of positional asphyxia. The NPM finds that face shields worn by staff should be used as a less intrusive alternative capable of achieving the same purpose. In 2024, the Ministry of Justice and Public Security requested that the Ministry of Health and Care Services carry out a comprehensive health-related assessment of the use of spit hoods within the correctional services.

In comparison, it is not allowed to use spit hoods on patients in mental healthcare hospitals. The Ombud has nonetheless found this practice in some hospitals and addressed this accordingly. Which in turn prompted the Directorate of Health to make an official statement (January 2024) declaring that spit hoods were not permitted according to the Mental Health Care Act.¹³

While spit hoods could previously be used on children if the strict legal requirements for coercive measures were met, Proposition 165 L (2024-2025) provides that the use of spit hoods on minors will no longer be permitted, once the relevant provisions enter into force.

The Committee is invited to ask the State party:

- **What is the status of the health-related assessment of the use of spit hoods in the Correctional Service, and how does the government intend to follow up on its findings?**

¹¹ Prop. 165 L (2024-2025) concerning amendments to the Norwegian Execution of Sentences Act, p. 107-108.

¹² See CPT, 21st General Report (CPT/Inf (2011) 28), para. 73.

¹³ Norwegian Directorate of Health, Spit Hoods Cannot Be Used as a Coercive Measure in Mental Health Care (Case No. 24/1594, 30 January 2024).

2.3.6 Regulating the use of physical force

There is not a statutory regulation of the use of physical force in the Execution on Sentences Act. The Ombud believes that a separate legal basis for the use of physical force should be examined, in order to protect prisoners from intrusive forms of physical coercion. The correctional services employ highly intrusive restraint and control techniques, which may be painful and carry a significant risk of injury if performed improperly, as well as a risk of violation of the prohibition against torture and ill-treatment. Furthermore, the absence of clear regulation may lead to violations of Article 2 of the ECHR in cases where prisoners lose their lives because of the use of such techniques.¹⁴

The State party should:

- **establish a separate legal basis for the use of physical force.**

2.4 Female inmates

Reference is made to CAT article 11; The Committee's list of issues para 18; State party's report para 160-163.

Over several years, the NPM has consistently expressed concern about the conditions for women in high-security prisons.¹⁵ Women have had limited access to activities, programmes and health services, while also presenting high levels of mental health needs, trauma and vulnerability.

In 2023, the NPM conducted an ad hoc visit to Bredtveit Prison and Preventive Detention Centre and identified extensive unlawful isolation, high levels of self-harm and suicide attempts, inadequate access to health care and serious shortcomings in staffing and management.¹⁶ The findings were considered so severe that the Ombud took the extraordinary step of immediately notifying the Ministry of Justice and Public Security before the final report had been completed. Following the closure of Bredtveit in 2023 due to fire safety concerns, the female prisoners were transferred to Skien and Ullersmo on short notice. Following the conversion of Skien Prison into a women's prison, the use of security cells and restraint beds increased significantly. However, from the summer of 2024, this use decreased substantially, and by the time of our visit in 2025, the prison had almost completely ceased using coercive measures. Our findings suggest that this change was linked to the prison's systematic efforts to prevent such use of force, in addition to relatively good staffing levels.¹⁷ However, recent developments raise concern about whether these improvements will be sustained in the context of increasing financial pressure within the Correctional Service.

Further concerns arise from the planned relocation of women from Ullersmo Prison to facilities in Kongsvinger and Kragerø. The NPM remains concerned that the physical conditions, regime and available services in women's units do not adequately address the specific needs of female prisoners. Thus, concerns remain that women in high-security prisons constitute a particularly vulnerable group and that further efforts are required to ensure detention conditions meeting their needs for meaningful out of cell-activities, safety and rehabilitation.

¹⁴ See ECtHR, *Kalkan v. Denmark*, Application No. 51781/22, paras. 97–130, 27 May 2025.

¹⁵ See for instance the Parliamentary Ombud (2017). *Women in Prison: A thematic report about the conditions for female prisoners in Norway*.

¹⁶ The Parliamentary Ombud (2023), *Critical and Life-Threatening Conditions at Bredtveit Prison and Detention Facility*, letter to the Ministry of Justice and Public Security, 23 March 2023.

¹⁷ The Parliamentary Ombud (2025). *Visit report – Telemark Prison, Skien Unit*, 10.10.2025.

The State party should:

- **strengthen its efforts to improve prison conditions for female inmates, in compliance with international human rights law and standards.**

2.5 Separation of children from adults

Reference is made to CAT articles 11; The Committee's list of issues para 18; State report para 164-165.

In June 2024, the NPM published a [special report on children held in Eidsberg Prison](#) for adults. The prison had an arrangement of accommodating up to three children between 15 and 18 years. The NPM found that these placements were contrary to the provision of the CRC that children should not be detained together with adults unless it is in the child's best interests. The minors were accommodated in units housing 11 adult prisoners. At times, they were left alone in the unit with adult prisoners without staff being present. Several district courts received incorrect information indicating that the prison had a separate "youth unit". The investigation also uncovered that between 2023 and early 2024, minors had been placed in adult prisons in 13 different adult high-security prisons across Norway. Following the report, the prison established a new separated wing designated to better screen minors from adult inmates.

Despite increases in places in the three juvenile units, the NPM remain concerned that children are placed in adult prisons. [In a visit report published in October 2026](#) from the juvenile unit at Ullersmo prison, the NPM found that a small number of children had been transferred from the juvenile unit to adult prisons. Some were subsequently subjected to isolation or coercive measures, including one case involving a particularly restrictive regime.

The State party should:

- **take additional measures to ensure that minors are not placed in adult prisons unless, following an individual assessment, such placement is determined to be in the best interests of the child.**

2.6 Maintaining contact with the outside world

Reference is made to CAT articles 2; The Committee's list of issues para 4 a) and d).

Based on visits to 29 high-security prisons from 2014 to 2024, the NPM [published a thematic report](#) in 2025 which identified a number of barriers limiting prisoners' ability to maintain contact with family and friends. Such contact is essential for prisoners' mental health and well-being, can play an important role in suicide prevention and supports rehabilitation and reintegration into society.

Currently, prisoners in high-security prisons are generally permitted to use the telephone for 30 minutes per week, while juveniles in prison are allowed to make at least three telephone calls per week, each lasting 20 minutes.¹⁸ The NPM visits indicate that prisons apply this provision of very limited telephone access strictly. In addition, practical obstacles, such as limited availability of telephones and expensive telephone charges, further impede prisoners' ability to maintain meaningful contact with family and friends. These barriers are even higher for prisoners with close family members abroad, as also background checks must be carried out before free video calls can be

¹⁸ See Section 3-29 of the Execution of Sentences Regulations.

arranged. In addition, language barriers may restrict interaction with other prisoners and staff and further increase the importance of contact with family and friends.¹⁹

The Execution of Sentences Act grants prisoners the right to receive visits but does not prescribe a minimum frequency or duration of visits.²⁰ The Norwegian Correctional Service's guidelines provide that, as far as practicable, prisoners should be granted at least one visit per week, and each visit should, as far as practicable, last at least one hour.²¹ Visiting arrangements vary between prisons. During one visit, the NPM observed that no ordinary visits were available at weekends. We have also seen examples where scheduled visits were cancelled at short notice due to staff shortages. For children, regular visits to a parent may be difficult to maintain when visits are only available on weekdays because of school etc. The ECtHR has found that a refusal to allow weekend visits violated a prisoner's right to family life under Article 8 of the ECHR. In its assessment, the Court noted that the prisons had relied on institutional capacity constraints without adequately considering the interest of prisoners and their families.²²

The Ombud is particularly concerned that in many prisons, requests for video calls are assessed according to the same rules as physical visits rather than ordinary telephone contact. As video calls do not involve physical contact, such restrictions appear disproportionate and risk unnecessarily limiting prisoners' contact with the outside world. In addition, concerns remain regarding prisons' failure to consider the best interests of children and their right to maintain contact with an incarcerated parent. Although prisoners may apply for extended telephone access, for instance if they have under aged children, findings suggest that this appears to be subject to strict practice across prisons.

Following its 2024 visit to Norway, the CPT recommended that the Norwegian authorities further enhance prisoners' opportunities to maintain contact with the outside world.²³ The Norwegian authorities should therefore review the regulatory framework and prison practices governing telephone calls, visits and video calls to ensure that prisoners have adequate opportunities to maintain meaningful contact with family and friends.

The State party should:

- **strengthen prisoners' opportunities to maintain regular contact with family and friends.**

2.7 Use of interpreters in prison

Reference is made to CAT articles 2 and The Committee's list of issues para 4 a).

In 2025, the NPM published a [thematic report on the use of interpreters in prison](#). Through our visits we have found serious deficiencies in the use of interpreters, especially upon admission and during the early stages of detention. These shortcomings undermined prisoners' ability to understand and exercise their rights, hindered the identification of health and welfare needs, and increased the risk of

¹⁹ The Parliamentary Ombud (2025), Thematic report: Prisoners' Opportunities to maintain contact with family and friends, Summary of Key Findings, 2014-2024.

²⁰ See Section 31 of the Execution of Sentences Act.

²¹ Norwegian Correctional Service Directorate, Guidelines to the Execution of Sentences Act, Section 31.10.

²² See ECtHR, *Subaşı and Others v. Türkiye*, Applications Nos. 3468/20 and 18 others, paras. 80–93, 6 December 2022.

²³ See CPT/Inf (2025) 03, para. 49, para 141.

unnecessary use of force and coercive measures. Taken together, the findings indicated a risk that prisoners who did not speak Norwegian could be subjected to inhuman or degrading treatment.

The State party should:

- **ensure that qualified interpreters are systematically provided whenever necessary, including upon admission and throughout detention, to ensure effective communication, access to rights and services, and protection against inhuman or degrading treatment.**

2.8 Healthcare services in prison

Reference to CAT article 11; The Committee's list of issues para 19; the State party's report paras. 169-171.

Healthcare services in Norwegian prisons follow an “import model”; primary healthcare services are provided by the municipality and specialist healthcare by the regional hospital. The responsibility of healthcare services to prisoners thus lies with the health authorities, rather than the prison authorities. Prisoners have poorer health and higher mortality rate than the general population, and recent studies indicate increasing prevalence of mental health and substance use disorders.²⁴ A recent study also show that prisoners, mostly men with known mental health disorders, in remand and in a high security prison had a much higher suicide rate than others.²⁵ The combination of high levels of illness, limited autonomy and freedom of movement, isolation, and legal powers permitting the use of force places a particular responsibility on the state to ensure healthcare for prisoners.

In its 2018 concluding observations (para. 20), the Committee reiterated its recommendation that Norway ensure adequate mental healthcare for prisoners with psychosocial disabilities and serious mental health conditions and abolish full isolation of persons whose mental health may be exacerbated by such measures. The findings presented below indicate that significant shortcomings persist in these areas.

In 2026, the NPM published a [thematic report on healthcare services in prisons](#) based on visits to fifteen prisons during 2023–2025. A key finding is that suicide risk is not systematically assessed at admission or during imprisonment. We found a general lack of attention to known vulnerabilities and risk factors for suicide, and thus a lack of systematic suicide prevention measures. The Ombud also found that prisoners with mental health problems and suicidal ideation are frequently being placed in isolation and in security cells, without adequate healthcare follow-up. Healthcare personnel are required to supervise prisoners in these circumstances at least daily, but our findings show that this requirement is not consistently met.²⁶ Furthermore, they seldom give specific support measures to prisoners with, inter alia, known psychosis, PTSD, ADHD, clinical depression, self-harm or suicidal ideation.

²⁴ Tverborgvik, T. et al. (2024). Living Conditions, Substance Use and Mental Health among Persons Who Have Been Imprisoned or Have Served Sentences in the Community. SERAF Report 5/2024; Svendsen, Vegard G. et al. Psychiatric morbidity among women in Norwegian prisons, 2010–2019: a register-based study. BMC psychiatry 23, no. 1 (2023): 390; Cramer, V. (2014). Prevalence of Mental Disorders among Convicted Persons in Norwegian Prisons, Oslo University Hospital.

²⁵ Bukten, A. et al. (2026). Rates, Timing and Correlates of Suicide in Norwegian Prisons: A 23-Year National Cohort Study. Archives of Suicide Research.

²⁶ Norwegian Directorate of Health (2025). Healthcare and Care Services for Prisoners: Guidelines to Legislation and Regulations. First published 22 September 2025.

Most health personnel do not actively question the security measures and use of force as determined by the prison and though trust between the two agencies is necessary and desirable on a general level, it can also entail blind spots and risk of ill-treatment. Findings indicate that healthcare services are often unaware when prisoners are subjected to de facto isolation. Unless prison staff or prisoners themselves communicate these conditions, healthcare follow-up may fail to address the factors affecting prisoners' health. This reflects a broader lack of coordination between the correctional and healthcare services, which operate largely in separate silos. Stronger cooperation and information-sharing at all levels, without breaching the duty of confidentiality, are needed to ensure that healthcare provision takes account of prisoners' actual conditions of confinement.

In *Haugen v. Norway* (15 October 2024), the ECtHR found a violation of Article 2 of the ECHR, holding that the Norwegian authorities had failed to take reasonable measures to protect the life of a remand prisoner with severe mental health problems who died by suicide while in detention.²⁷ The Ombud considers that several of the shortcomings described in *Haugen v. Norway* are of a systemic nature and therefore require systemic solutions. These relate to challenges within the prison system and provision of healthcare per se, but also to challenges of cooperation between the Correctional Services and healthcare institutions as well as between different levels of healthcare, as described above. The Norwegian Healthcare Investigation Board highlighted similar concerns in a newly published report.²⁸

The State party should:

- **strengthen coordination and cooperation between correctional and healthcare services, and between different levels of healthcare, to ensure timely, continuous and appropriate healthcare for prisoners, including systematic suicide prevention and adequate follow-up of prisoners with mental health conditions held in isolation or security cells.**

3. Police establishments

3.1 Immigration detention

Reference is made to CAT article 11; The Committee's list of issues paras 13, 18 and 20; the State party's report para. 75, 104, 150, 156, 160-163, 172-175; CAT Concluding Observations 2018, paras. 27-28.

3.1.1 Overview

The Police Immigration Detention Centre, Trandum is situated close to Oslo Airport Gardermoen. The detention centre is currently run by the National Police Immigration Service but are intended to be

²⁷ ECtHR, *Haugen v. Norway*, Application no. 59476/21, judgment of 15 October 2024.

²⁸ Norwegian Healthcare Investigation Board (Ukom). *Between punishment and healthcare – patient safety for prisoners with severe mental illness*, 26 May 2026.

transferred to the Norwegian Correctional Service from 1 January 2027.²⁹ The NPM has visited the centre three times.³⁰ The last visit was from 23-25 November 2025.³¹

3.1.2 Prison-like conditions

The Committee has repeatedly expressed concern about the conditions for detainees at the Police Immigration detention centre, Trandum.³² These concerns have also been raised by the NPM, which has been critical of the extensive use of restrictions and security measures at the detention centre.³³ Since the NPM's previous visit in 2017, we found in 2025 that the procedures had clearly improved, as detainees can now leave their rooms and spend time together with others for most of the day. In 2026, there was also installed a body scanner, to reduce the need for body searches.

However, the centre still retains characteristics of a prison. The detainees are confined to their rooms for 9.5 hours during the night. In a recent law proposal, a new legal provision is suggested allowing detainees to be confined in their room "at night". Such confinement may not exceed 12 hours. Under the proposal, an individual assessment must be made as to whether the measure is proportionate and after 72 hours a specific assessment must be carried out to determine whether the confinement should be maintained.³⁴ The Ombud considers a general rule providing for night-time confinement to be neither necessary nor proportionate. Furthermore, the Ombud is concerned that the admission procedures at the centre are inadequate to ensure that the Correctional Service can undertake an individualized and meaningful proportionality assessment before imposing or maintaining such confinement.³⁵

In LOIPR, paras. 20, the Committee asks for information regarding measures to ensure detainees at Trandum have sufficient access to outdoor exercise and to educational and recreational activities for a reasonable part of the day. In its follow-up, the State party informs that detainees at that time (21 September 2021) was entitled to at least one hour of outdoor time daily, in addition to daily access to the activity centre for approximately 60-90 minutes. In the NPM report from the visit in November 2025, we found that access to the activity centre was limited to three times a week for 90 minutes per session. This represented a reduction from five sessions per week approximately two years prior to our visit. According to the institution, the reduction was justified by improved access to outdoor exercise yards and a decline in detainees' use of the activity centre. The NPM, however, assessed that detainees had access to only a limited range of meaningful activities and recommended strengthening the activities to mitigate the adverse effects of detention.

²⁹ Proposition 2 L (2026-2027) Amendments to the Immigration Act (transfer of the operation of the Immigration Detention Centre from the police to the Norwegian Correctional Service) is currently being considered by the Norwegian Parliament.

³⁰ We have not yet visited the family unit, which is separate from Trandum, and situated at Hurdal.

³¹ The first visit was from 19-21 May 2025, and the second visit from 28-29 March 2017. Note that the Parliamentary Ombud had visited the immigration centre on several occasions before it was designated NPM.

³² See for instance CAT/C/NOR/CO/6-7, para 15; CAT/C/NOR/CO/8, paras. 27-28.

³³ In addition to visit reports and consultation responses, the NPM has also submitted an *amicus curiae* brief to the Borgarting Court of Appeal in a case concerning the conditions at the Trandum Immigration Detention Centre as they relate to an adult detainee.

³⁴ Proposition 2 L (2026-2027), Amendments to the Immigration Act, p. 34-39.

³⁵ Parliamentary Ombud (2026), Response to Consultation on Proposed Amendments to the Immigration Act and Related Legislation: Transfer of Responsibility for the Operation of the Immigration Detention Centre from the Police to the Correctional Service, 29 May 2026.

The NPM also found that the facilities are not designed for prolonged stays. Nevertheless, several detainees remained there for many months. Such lengthy stays are particularly burdensome and require close monitoring of the detainees' health. We found that some detainees developed symptoms associated with the harmful effects of isolation.

3.1.3 Treatment of detainees

Although many detainees described being adequately cared for by staff, several detainees said that they experienced the centre as unsafe and that they were treated poorly by staff. Some described staff as speaking rudely and behaving aggressively, threatening to use the security unit and shouting at detainees. This was corroborated by case records, which, for example, described detainees as needing a "firm hand". The lack of common education and training among staff appeared to contribute to many detainees experiencing disrespectful treatment. It also increased the risk of conflict and the use of coercive measures. In the Ombud's response to the consultation on proposed amendments to the Immigration Act, we highlighted the need for increased training and competence among the centre's staff, and that this need to be an important aspect of the transfer of responsibility from the Police to the Correctional Services.

3.1.4 Particularly vulnerable detainees

In the documentation from the detention centre, we found several examples of detainees in particularly vulnerable situations. Several of those who had been detained for long periods had mental health problems and suicidal thoughts, and there had been several suicide attempts. Our findings consistently indicate inadequate assessment and follow-up of suicide risk, both by the immigration detention centre and the health unit.

The NPM recommended, among other things, that the municipality responsible for operating the health unit should ensure adequate health care and follow-up throughout the period of detention, particularly regarding mental health and detainees who remain at the centre for extended periods.

In LOIPR, para 13, the Committee asks for information regarding training programmes for medical professionals and other public officials on, inter alia, the Istanbul Protocol. In our last visit to Trandum, we found no examples of previous experiences of torture being documented in the medical records we reviewed. There was little or no awareness of the Istanbul Protocol. Following the visit by the CPT to the detention centre in 2024, the CPT made several recommendations to the authorities concerning the identification of vulnerabilities and previous traumatic experiences. The CPT emphasised that healthcare professionals can play an important role in identifying and documenting injuries and, in doing so, contribute to the prevention of ill-treatment.³⁶

3.1.5 Use of the security unit and security cells

The NPM identified several matters of concern regarding the centre's use of the security unit. Detainees are subject to considerably stricter conditions there than in the communal units, and they may also be placed in a security cell. The NPM identified several shortcomings in the decisions to place detainees in the security unit and in security cells. The documentation also revealed serious deficiencies in the follow-up of detainees who were isolated in the security unit or in security cells.

³⁶ See CPT/Inf (2025) 03, paras. 52-53.

We found several examples of the use of force during stays in the security cell, including one case in which pepper spray was used inside the security cell. The NPM is critical of the fact that the use of pepper spray is considered necessary inside a security cell. We emphasized in our report that both the CPT and the CAT have stated that pepper spray should not be used in confined spaces.³⁷

Staff reported that body cuffs and protective helmets could be used inside the security cells during continuous supervision of persons who were self-harming. The NPM is concerned that the detention centre responds to a person at imminent risk of suicide with such intrusive coercive measures.

The Ministry has proposed that the conditions for the use of a security cell in relation to children should be particularly stringent, and that a security cell may only be used for a minor when it is imperative in order to save life. The NPM maintains that there should instead be an absolute prohibition on the use of security cells for children held at the Immigration Detention Centre.

3.1.6 Non-refoulement

A new topic that has sparked controversy in recent years, is visits from foreign delegations to the detention centre. In our report, we note that where foreign nationals are compelled to appear before representatives of authorities from countries from which they have previously sought protection, such encounters may give rise to a new need for international protection. We also noted that the use of coercion in connection with such appearances may entail a risk of inhuman or degrading treatment. If the Correctional Service is to facilitate visits by foreign delegations to the Immigration Detention Centre, this should be accompanied by clear procedural safeguards for detainees, including access to an interpreter and legal counsel. Such safeguards would also help ensure that staff are not placed in difficult or inappropriate situations. The Ombud recommends that these safeguards be explicitly set out in the regulations.³⁸

3.1.7 Risk of inhuman or degrading treatment

In conclusion, the NPM findings show that there are still conditions at the centre that may create a risk of inhuman or degrading treatment. The NPM is particularly concerned about the inadequate follow-up of those who remain at the centre for extended periods and particularly vulnerable detainees, as well as with the use of security cells.

The State Party should:

- **ensure that detainees at heightened risk of suicide and self-harm should be supported through evidence-based prevention measures, including increased human contact, care, and purposeful activities, rather than restrictive interventions.**

³⁷ The CPT has also recommended that staff should not routinely carry pepper spray or batons within the immigration detention centre. See CPT/Inf(2025) 03, para. 69.

³⁸ In an instruction issued on 16 October 2026, the Ministry of Justice stated that it is working on new rules governing the legal assistance available to foreign nationals in such situations, see GI-06/2026, available at: <https://www.regjeringen.no/contentassets/2f9951f360a14318b8cb0ecf07d0d8ec/instruks-om-advokaters-adgang-til-a-vare-til-stede-mv.-ved-fremstilling-for-hjemlandets-myndigheter-i-utlendingssaker-1-2.pdf>

- **take further steps to ensure that the conditions and regime at the immigration detention centre reflects the administrative nature of the detention, with only those restrictions necessary for its purpose and with a non-carceral environment and regime.**

3.2 Police custody

Reference is made to CAT article 2 and 11; The Committee's list of issues para. 4 and 14-15; the State party's report paras. 12-18, 110-115, 121.

3.2.1 Overview

Since 2018, the NPM has conducted two unannounced visits to police custody facilities: A visit to Oslo Police District in 2021 and a visit to the holding cells at Oslo District Court in 2023.

3.2.2 Fundamental legal safeguards

In 2024, amendments to the Police Custody Instructions entered into force. Positive developments include requirements that at least two police officers be present in custody facilities, more detailed custody record-keeping, stricter conditions for cell-sharing arrangements, and strengthened safeguards governing body searches. While these changes are welcome, the NPM remains concerned about their practical implementation and monitoring in practice.

Following its visit to Norway in 2024, the CPT highlighted three safeguards as particularly important for preventing ill-treatment in police custody: prompt notification of relatives or trusted persons, access to a lawyer from the outset of deprivation of liberty, and medical examination where injuries consistent with police violence are observed. The NPM notes with concern that these issues receive limited attention in local inspection reports. Furthermore, there have been no legislative changes addressing the concern raised by the CPT that many detainees may not gain effective access to legal counsel until they have spent a substantial period in police custody.

3.2.3 Use of force or coercive measures

The revised instructions expressly clarify that any use of force or coercive measures must be strictly necessary, consistent with the European Court of Human Rights' judgment in *Bouyid v. Belgium*.³⁹ However, the Ombud remains concerned about the range of coercive devices permitted in police custody facilities, including pepper spray, body cuffs, spit hoods and conducted energy devices.

3.2.4 Conditions of detention

In its previous concluding observations, the Committee recommended that Norway should expand or refurbish police detention facilities with inadequate conditions (CAT/C/NOR/CO/8, para.6-7, para 10). The 2024 revisions introduced differentiated cell standards and new requirements for remand cells, including access to a clock, table, chair, mirror and information about rights. However, the

³⁹ ECtHR, *Bouyid v. Belgium* (Grand Chamber), Application No. 23380/09, judgment of 28 September 2015, para. 100: «in respect of a person who is deprived of his liberty, or, more generally, is confronted with law-enforcement officers any recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is, in principle, an infringement of the right set forth in Article 3».

instructions do not specify how many cells within a detention facility must meet these standards. Nor do they clearly distinguish between mandatory minimum requirements and desirable standards.⁴⁰

The NPM remains concerned that there may be a significant gap between the revised framework and actual conditions in existing facilities. Information available from recent local inspection reports suggests that many detention facilities have yet to be upgraded.

The NPM's 2021 investigation of children's use of police custody found a lack of appropriate alternatives to detention cells. The cells designated for minors remained, in practice, largely indistinguishable from ordinary holding cells. The revised instructions now contain specific requirements concerning the design and equipment of cells intended for children. Nevertheless, local inspection reports from 2026 indicate that several police districts still lack dedicated facilities for persons under the age of 18. The NPM recommends that all children deprived of their liberty be accommodated in child-appropriate facilities and that they receive information about their rights in a child-friendly format from the outset of their detention.

3.2.5 Police custody beyond 48 hours

The Committee has repeatedly expressed concern about detention in police custody beyond the statutory 48-hour limit (CAT/C/NOR/CO/8, para.6-7, para 14 and 16). The number of detainees held in police custody beyond the statutory time limit has increased since 2022, although it remains lower than in earlier years. Most of the stays beyond the 48-hour limit are of relatively short duration. However, the NPM remains concerned that a small number of detainees continue to spend prolonged periods in police custody, sometimes lasting several days.⁴¹

Suggested recommendation:

- **The State party should ensure the effective implementation of the revised Police Custody Instructions throughout the country, including through adequate resources, monitoring and oversight. It should accelerate the refurbishment of police detention facilities, ensure the availability of child-appropriate accommodation in all police districts, strengthen fundamental safeguards from the outset of detention, and take further measures to eliminate detention in police custody beyond the statutory 48-hour limit.**

4 Mental health care hospitals

Reference is made to CAT article 2 and 11; The Committee's list of issues para. 22-23; the State party's report para. 185-196.

4.1 Overview

Since 2018, the NPM has conducted visits to 17 mental health care hospitals, including psychiatric wards for children, adolescents and elders, psychiatric emergency wards and local and regional secure psychiatric wards.

⁴⁰ Parliamentary Ombud (2023), Consultation Response on the Revised Instructions for the Use of Police Custody Facilities.

⁴¹ National Police Directorate (2026), Central Custody Inspection Body, Annual Report 2025.

4.2 Prolonged use of mechanical restraints

The Committee has previously expressed concern about the widespread use of restraints and other coercive measures in Norwegian mental health care hospitals, as well as weak procedural safeguards (CAT/C/NOR/CO/8, para. 21). In its report (CAT/C/NOR/9, paras 185-193), the State party has not reported on any specific measures to limit the use of coercive measures, other than statistical information on the incidence of coercive measures and information on ongoing legal reforms. For several years, there have been no publicly available statistics on the use of coercive measures in mental health care (see section 4.2 of this report).

Recent findings by the NPM show significant challenges concerning prolonged use of mechanical restraints. Findings from all hospitals visited reveal serious shortcomings in the required continuous assessments of whether the restraints remain strictly necessary throughout its duration. In all hospitals, we found cases where the available documentation indicated that the restraints were unlawful. This largely concerned the use of mechanical restraints that lasted long after the acute situation had subsided.

The NPM has also identified several cases of exceptionally prolonged restraint, in many cases lasting for days and even weeks on end. In one case, a patient spent more than 44 days continuously strapped to a restraint bed, at times with only weekly reassessments of whether to lift the measure.⁴² In all 6 mental health care hospitals visited in the period from 2025–2026 patients had in several instances spent more than 24 hours in mechanical restraints, most hospitals also had restrained patients for more than 48 hours. In addition, at most of the hospitals a few patients had been subjected to even longer periods of restraint, ranging from over 5 days to more than 18 days. In several of the exceptionally prolonged cases we reviewed, patients were described as calm and cooperative for prolonged periods without the restraints being discontinued.

In addition, the Parliamentary Ombud has identified weaknesses in the Control Commissions'⁴³ scrutiny of the duration of restraint. In a [systematic review from 2022 of 59 Control Commission decisions](#) based on complaints from patients on the use of mechanical restraints, more than half did not demonstrate an adequate assessment of whether the requirement of strict necessity continued to be met throughout the entire period of restraint.⁴⁴ Findings from NPMs visits in 2026–2026 show that shortcomings remain in the Commissions' control of the use of mechanical restraints. While the weaknesses we identified includes the assessments of the commissions when handling complaints from patients, the most important finding is that the Commissions' ex-officio reviews of the duration of mechanical restraints in many cases were inadequate.

These findings raise serious concern that the use of mechanical restraints against patients in mental health care hospitals often may be prolonged beyond the period which is strictly necessary and proportionate. Considering the high risk of physical and psychological harm associated with

⁴² See the Parliamentary Ombud's follow-up of Østfold hospital, available at: <https://www.sivilombudet.no/aktuelt/oppfolging-av-sykehuset-ostfold/>

⁴³ The Control Commission safeguards the legal rights of individuals in their interactions with mental health services. The Commission reviews decisions involving compulsory measures, considers complaints, and monitors patients' welfare.

⁴⁴ Parliamentary Ombud (2022). Control of the Use of Mechanical Restraints in Mental Health Care: Report from an Own-Initiative Investigation.

prolonged restraint for patients, these systematic shortcomings indicate high risk of violations of the prohibition of inhuman and degrading treatment (UN CAT article 2 cf. 16).

A legislative amendment that entered into force in June 2026 explicitly set out in the Mental Health Care Act the requirement to continuously assess whether the conditions for the use of coercion remain fulfilled. At the same time, new regulations provide that decisions on mechanical restraints may last for a maximum of eight hours, after which a new written decision is required. While this is welcome procedural improvements, there is a need for additional measures by the State party.

The state party should:

- **Introduce stricter legal safeguards to avoid cases of prolonged use of mechanical restraint. These regulations should establish minimum requirements for the content of ongoing assessments of the decision to use mechanical restraints and specify how frequently such assessments must be documented.**

4.3 The need for improved systematic prevention of the use of coercive measures

The NPM is concerned that, for several years, the health authorities have not had any updated, reliable and sufficiently comprehensive publicly available national statistics on the use of coercive measures (including mechanical restraints) in mental health care. Moreover, there has never existed any national statistics with reliable information regarding the duration of mechanical restraint. This is a significant gap, as the duration of restraint is a crucial factor when assessing the necessity, proportionality and potential risks associated with its use. Publicly available statistics should be sufficiently detailed to enable the authorities, oversight bodies and the public to monitor trends, identify prolonged use and assess the effectiveness of measures aimed at reducing coercion.

The NPM's findings from several visits to mental health care institutions indicate that the use of mechanical restraints is not consistently followed by systematic measures to prevent future or prolonged use of coercive measures. In particular, the NPM has found that follow-up conversations with patients are often not conducted after the use of coercive measures. Moreover, when such conversations did take place, lessons are not systematically used to prevent further coercion.⁴⁵ Such experiences can provide important information about the circumstances leading to coercion and about measures that could have prevented or shortened its use.

The NPM has also identified a need for better training of decision-makers in the strict legal requirements governing the use of coercive measures, including the requirements of continuous assessments of necessity and proportionality. Furthermore, locally available data on the use of coercive measures are often not systematically analysed and used as a basis for quality improvement and preventive work. This limits the ability of institutions to identify patterns, recurring risk factors and opportunities to reduce coercion.

The state party should:

⁴⁵ The Mental Health Care Act Section 4-2 requires health care personnel to offer patients at least one conversation as soon as possible after coercive measures has been used.

- **take steps to ensure reliable, comprehensive and publicly accessible statistics on the use of all coercive measures in mental health care, including the type, frequency and duration of the use of restraints.**
- **introduce a statutory duty on mental health care institutions to work systematically to prevent the use of coercive measures.**

4.4 Involuntary medication

With reference to the Committee's list of issues, paras. 22 a)-d); the State party's report 185-194; CAT Concluding observations 2018 paras. 21-22.

In its previous concluding observations (para. 21-22), the Committee reiterated its concerns regarding involuntary administration of neuroleptic drugs and other psychotropic medication. Since 2018, the NPM has not conducted visits with a thematic focus on involuntary medication. However, the Parliamentary Ombud has, in recent years, issued a series of statements in cases concerning the County Governors' interpretation of involuntary medication under section 4-4 of the Mental Health Care Act. According to Section 4-4, treatment without the patient's consent "... may only be initiated and carried out where it is *highly likely* to lead to the patient's recovery or a *substantial* improvement in the patient's condition, or to prevent a *substantial* deterioration of the illness." (*our emphasis*).

The Ombud has repeatedly identified shortcomings in the interpretation and application of the statutory requirement that involuntary treatment may only be administered where it is highly likely to result in recovery, a substantial improvement in the patient's condition, or prevent a substantial deterioration of the illness. The Ombud has emphasised that the requirement of a "high probability" sets a higher threshold than the ordinary balance of probabilities and must be assessed in relation to the individual patient. Furthermore, there must be a high probability of a therapeutic effect that is sufficiently significant. Given the intrusive nature of involuntary medication, a general reference to research findings or clinical experience is not in itself sufficient to satisfy these requirements.

The issue is particularly acute in cases involving first-time administration of antipsychotic medication. In such cases, there is normally no prior individual experience of the medication that can inform the assessment of likely treatment outcomes. Decisions therefore tend to rely primarily on general research evidence. At the same time, the evidence base referred to by the authorities acknowledges that there are currently no clinical methods capable of predicting treatment response at the individual level.

In several cases, the Ombud has questioned whether the statutory requirement of a high probability of a substantial therapeutic benefit can in fact be satisfied in first-treatment cases where there are no individual indicators of expected effect. This raises concerns not only about the reasoning provided in individual decisions, but also about whether the substantive legal conditions for such a highly intrusive intervention are fulfilled.

The issue has been recognised in Norwegian law reform processes for many years. The Coercion Legislation Committee (*tvangsbegrensningslovutvalget*) (NOU 2019:14) specifically addressed the difficulties associated with applying the current statutory threshold in cases of first-time compulsory medication and proposed legislative changes. In Proposition 31 L (2024–2025), the Ministry of Health

followed up certain proposals from both the Consent Committee and the Coercion Legislation Committee. On that basis, the Norwegian Parliament adopted several amendments to the Mental Health Care Act and the Patient and User Rights Act. However, the Coercion Legislation Committee's proposal for amendments to the current provision on involuntary medication has not yet been implemented. Thus, the issue of the evidentiary threshold for the initial administration of compulsory medication remains unresolved.

The State party should:

- **expedite the ongoing legislative review of coercive mental health care measures and take steps to ensure that the fundamental principles of legality, necessity and proportionality are respected when considering intrusive treatments against a person's will.**

5 Residential child welfare institutions

With reference to CAT Articles 2, 11 and 16; the Committee's list of issues para. 23; the State party's report para. 106, 197-199.

5.1 Overview

From 2018 to the time of reporting, the NPM has undertaken visits to 12 child welfare institutions.

5.2 Lack of effective safeguards against violence, exploitation and abuse

The State has an obligation to exercise oversight of all institutions caring for children and to ensure that effective safeguards are in place to protect children from violence, exploitation and treatment contrary to Articles 2 and 16 of the Convention. The Committee on the Rights of the Child (CRC) has also emphasised that children living in care institutions are particularly vulnerable and that States must ensure effective supervision and monitoring of all institutions responsible for their care.⁴⁶

A finding from several of the institutions visited by the NPM, was that the institutions procedures for the prevention and management of abuse were not known to staff. Violence and abuse appeared to be discussed and reflected upon only to a limited extent within the institution. These findings raised concerns about the effectiveness of institutional safeguards aimed at preventing violence, abuse and other forms of ill-treatment of children in residential care. Procedures for reporting must ensure that the youth living in the institutions are informed about how to safely report if a violent or abusive act has occurred.

Furthermore, a recent report indicates that criminal actors hold key positions in private companies providing child welfare services to municipalities and the State.⁴⁷ The report found that criminals may exploit the child welfare sector to engage in labour-related crime. This also creates a risk that children may have close contact with adults who have active links to criminal networks. As a result of

⁴⁶ See CRC/C/GC/13, paras. 44(b) and 72(g)).

⁴⁷ South-East Police District (2026), *OP Welfare: Risk in Private Child Welfare Services in the South-East Police District (SØPD)*, 25 August 2026.

the report, one institution has so far lost its license, and the children in that institution have been moved. The government has also initiated several other measures as a follow-up of the report.⁴⁸

The NPM is deeply concerned that weaknesses in oversight and control mechanisms may have allowed individuals with criminal affiliations to occupy positions of influence within institutions caring for children on behalf of the State. Such shortcomings increase the risk of abuse, exploitation, criminal recruitment and other forms of ill-treatment of an especially vulnerable population.

The State party should:

- **strengthen safeguards to protect children placed in residential care from violence, abuse, exploitation and recruitment into criminal networks. This includes ensuring vetting of owners, managers and staff, procedures for reporting and effective oversight mechanisms.**

5.3 Risk of social isolation

In January 2023, the NPM visited eleven separate units where children lived alone in residential care, operated by three different providers. None of the children visited were subject to a formal single-placement decision. Nevertheless, several had lived alone in residential care for extended periods, in some cases for several years. In several instances, the NPM found no documented assessment of whether the arrangement was in the child's best interests. Furthermore, the children's views on living alone had not been systematically sought or documented.

In an earlier visit, the NPM also found examples of children placed under coercive measures that had minimal contact with peers and little or no access to schooling or organised activities. The NPM concluded that there were grounds for concern that the institution was failing to compensate for the isolation-like conditions in which these children lived. Such conditions may entail a risk of inhuman or degrading treatment.⁴⁹

According to section 10-6, second paragraph of the Child Welfare Act, child welfare institutions must, when assessing the necessity and proportionality of restrictions and interventions, consider their cumulative extent and duration. The provision explicitly provides that consideration shall also be given to whether the child is accommodated alone. However, the section does not ensure regular assessments of whether living alone remains in the child's best interest. Given the NPM's findings of prolonged periods of solitary living and limited contact with peers, stronger safeguards are needed to ensure that children are not exposed to isolation-like conditions for longer than is strictly necessary.

The State party should:

- **ensure, through legislation or national guidelines, that the risk of social isolation is continually assessed for each child in order to protect children from living under such conditions.**

⁴⁸ Norwegian Ministry of Justice and Public Security and Ministry of Children and Families, New Report on the Risk of Labour Exploitation and Work-Related Crime among Private Providers of Child Welfare Services, Press Release, 26 August 2026, available at: [Ny rapport om risiko for arbeidslivskriminalitet hos private leverandører av barnevernstjenester - regjeringen.no](https://www.regjeringen.no/no/nyheter/ny-rapport-om-risiko-for-arbeidslivskriminalitet-hos-private-leverandorer-av-barnevernstjenester-regjeringen.no)

⁴⁹ The Parliamentary Ombud (2019). Visit report – Stendi AS, Nygårdsmoen Child Welfare Institution.

5.4 Need for overall assessment of intrusive measures

In recent years, there has been considerable debate in Norway concerning children who place their own development at serious risk, including children who commit serious or repeated criminal offences. This debate has led to a number of public inquiries and several amendments to Norway's child welfare legislation.⁵⁰ In January 2026, the authority to use physical force in acute emergency situations and in situations involving an imminent risk of serious harm was clarified and somewhat expanded.⁵¹ Furthermore, in June 2026, a new legislative amendment was passed in Parliament which broaden the scope of child welfare institutions' powers to implement intrusive measures. The measures include restrictions on freedom of movement and communication and, in certain cases, the use of physical force.⁵² These changes form the first stage in a broader reform process, and further proposals are pending concerning, inter alia, children who commit, or are at risk of committing, repeated serious criminal offences.

Findings from our visits to residential child welfare institutions have documented recurring challenges relating to compliance with the legal framework governing the use of coercion and force, including instances of unnecessary or disproportionate use of coercive measures. Staff in many of the institutions we visited lacked necessary competence and demonstrated uncertainty regarding the interpretation of the relevant provisions. Against this backdrop, the NPM is concerned that the piecemeal expansion of the statutory powers to use coercive measures has been introduced without a comprehensive assessment of the cumulative impact of existing and proposed provisions.⁵³

The State party should:

- **conduct an overall assessment of the legal framework governing the use of coercion and force in residential child welfare institutions, including an assessment of whether existing safeguards are sufficient to prevent ill-treatment and ensure compliance with the Convention. Any further expansion of coercive powers should be preceded by a thorough evaluation of current practice, compliance with existing legislation, and the cumulative impact of coercive measures on children.**

6 Residential homes for persons with intellectual disabilities

6.1 Overview

During 2020-2022 the NPM conducted visits to 15 residential homes for persons with intellectual disabilities in four municipalities in Norway. The findings were summarised in four visit reports, and [one thematic report](#). The visits revealed serious concerns regarding the treatment of persons with intellectual disabilities. Residents were unlawfully locked in their rooms and separated from others

⁵⁰ Norwegian Expert Group on Measures for Children Who Commit Repeated or Serious Criminal Offences, *They Are Our Children: Keeping a Cool Head and a Warm Heart*, Report to the Government of Norway.

⁵¹ See Proposition No. 86 L (2025–2026): Amendments to the Child Welfare Act (Enhanced Protection for Children in Residential Care)

⁵² See Proposition No. 86 L (2025–2026), Recommendation to the Storting No. 362 L (2025–2026), Legislative Decision No. 86 (2025–2026).

⁵³ Parliamentary Ombud (2025), Consultation Response to the Report of the Expert Group on Measures for Children Who Commit Repeated or Serious Criminal Offences, submitted to the Ministry of Justice and Public Security and the Ministry of Children and Families, 22 September 2025.

without formal authorisation, while the living arrangements created a significant risk of coercion, segregation and isolation. The visits also revealed shortcomings in healthcare provision and insufficient competence to identify and prevent violence, abuse and neglect.

6.2 Lack of on-site supervision of people with intellectual disabilities

Norwegian law does not have a special provision for the confinement of people with an intellectual disability, but even so, in practice they may be subjected to extensive limitations, in some cases amounting to deprivation of liberty. Many are also dependent on their living arrangements being facilitated. As such, persons with intellectual disabilities are vulnerable to having their basic rights violated.

The use of coercion and force is regulated by the Health and Care Services Act. While the statutory framework imposes stringent safeguards, municipalities retain considerable discretion in determining which coercive measures may be adopted where the legal conditions are met. Municipalities therefore bear significant responsibility for ensuring that coercive interventions are lawful, necessary and proportionate. During its visits, the NPM encountered residents who were unlawfully confined to their rooms and residents who were separated from other residents without any formal decision authorising such restrictions.

Decisions authorising the use of coercion are subject to prior review and approval by the County Governor before they may be implemented. As part of this review, the County Governor must assess whether the statutory requirements for the use of coercion have been satisfied and whether the proposed measures are necessary, proportionate and ethically justifiable. During its visits, the NPM have found instances where coercive measures had been applied for extended periods without a valid legal authorisation in force.

The findings indicate a need for enhanced oversight and more systematic monitoring of the human rights situation of persons with intellectual disabilities who are subject to intrusive coercive interventions. However, the legal framework does not prescribe the frequency of the County Governors supervision of persons with intellectual disabilities through on-site inspections.⁵⁴ In 2025, the Norwegian Board of Health Supervision reviewed the County Governors' supervision of persons with intellectual disabilities through on-site inspections. The report found that the number of individuals subject to coercive measures decisions increased to 2,005 in 2024, yet only 9.6 per cent received an on-site supervisory visit during that year. Some individuals had not been subject to an on-site inspection since before 2012.⁵⁵ Half of the inspections identified the use of coercive measures that were not implemented in accordance with the relevant decisions or statutory requirements. Significant variation was found between the County Governors, highlighting the need for measures to strengthen and harmonise supervisory practices. The findings mirror concerns identified by the NPM during visits between 2020-2022, suggesting that these issues have persisted over time.

⁵⁴ Norwegian Board of Health Supervision, "We Need More On-site Inspections of the Use of Coercion and Force on Persons with Intellectual Disabilities", *Tilsynsmeldingen* (2026)

⁵⁵ Norwegian Board of Health Supervision, *Review of the County Governors' On-site Inspections of Services for Persons with Intellectual Disabilities*, Report 6/2025 (2025), available at: https://www.helsetilsynet.no/publikasjoner/rapport-fra-helsetilsynet/2025/gjennomgang_statsforvaltnes_arbeid_stedlige_tilsyn_personer_utviklingshemming/#

Suggested recommendation:

- **The State party should strengthen the monitoring and oversight of persons with intellectual disabilities who are subjected to coercive measures, including by ensuring that the County Governors carry out sufficiently frequent on-site inspections to identify and prevent violations of their rights.**

7 Nursing homes

7.1 Overview

During 2020-2022, the NPM conducted visits to five nursing homes in four municipalities. The findings were summarised in four visit reports, and [one thematic report](#).

7.2 Unlawful coercion and lack of knowledge

According to Chapter 4A of the Patient and User Rights Act, coercive measures may only be used to provide necessary somatic healthcare to persons who lack decision-making capacity and oppose treatment. The legislation establishes strict substantive and procedural safeguards, including a requirement for individual decisions, documentation, notification to the patient and their next of kin, and external oversight by the County Governor.

In its summary report of the visits to nursing homes, the NPM highlights several serious shortcomings in the protection of residents against unlawful coercion and other forms of ill-treatment. The findings revealed that residents, particularly those with dementia or cognitive impairments, were subjected to extensive restrictions on their freedom of movement, including locked doors, complex door codes and concealed door-opening mechanisms, without the legally required individual decisions authoritising such restrictions.⁵⁶

The NPM also found widespread uncertainty among staff regarding the legal framework governing coercive measures. For instance, we identified instances of unlawful coercion during personal care and hygiene procedures in several nursing homes. For example, staff at one institution generally considered it permissible to physically restrain residents in order to wash them following episodes of incontinence, or to use several staff members to hold residents during care procedures if they resisted by kicking or hitting, without adopting a formal decision under Chapter 4A of the Patient and User Rights Act. The failure to issue formal decisions and document such coercive measures constitute a serious deficiency in the legal safeguards afforded to these residents. The visits further revealed inadequate awareness and preventive measures concerning violence and abuse against older persons, including abuse committed by staff, relatives or other residents. Several institutions lacked clear procedures for preventing, detecting and responding to violence and abuse. Given the high level of dependency among many nursing home residents, particularly those with dementia or cognitive impairments, these shortcomings raise concerns regarding the State's ability to protect residents from ill-treatment.

⁵⁶ See also Norwegian Official Report (NOU) 2019:14, *The Coercion Limitation Act (Tvangsbegrensningsloven)*, Chapter 6.5, p. 150.

7.3 Lack of awareness about risk of violence and abuse

Several of the visited nursing homes and municipalities lacked clear routines for preventing and handling violence or abuse against residents. Following its visits the NPM underlined that this increases the risk of violence and abuse against nursing home residents going undetected or not being properly followed up.

The State party should:

- **take effective measures to prevent ill-treatment in nursing homes, including by ensuring that staff have sufficient knowledge of the legal bases for care and use of force and by strengthening independent oversight.**
- **take effective steps to ensure that procedures for preventing and handling violence, threats, and abuse against both residents and staff are in place and being followed.**