



**SIVILOMBUDET**  
Norwegian Parliamentary Ombud

**VISIT REPORT** | no. 85

**SUMMARY AND RECOMMENDATIONS**

**Romerike Prison,  
Ullersmo Unit**

**February 5 to 6, 2025**



**National Preventive Mechanism against  
Torture and Ill-Treatment**



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National Preventive Mechanism

## **Visit report**

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## I. The Parliamentary Ombud's prevention mandate

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

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

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

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

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

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

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

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

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<sup>1</sup> Sections 1, 17, 18 and 19 of the Norwegian Parliamentary Ombud Act.

<sup>2</sup> UN Subcommittee on Prevention of Torture (SPT), Prevention Mandate Recommendations, 30 December 2010 CAT/OP/12/6.

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

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

## II. Summary

Placement in a security cell is a coercive measure that exposes the prisoner to a high risk of inhuman or degrading treatment.

The Parliamentary Ombud's National Preventive Mechanism therefore examined the use of security cells in Romerike Prison, Ullersmo Unit. During the period 1 January 2024 – 6 February 2025 the prison made 27 placements in a security cell.

### **Particularly burdensome physical conditions**

The prison's three security cells are in a separate corridor, separated from the other units. The cells are very small and offer no real possibility of looking out. With few sensory stimuli, the conditions are extremely onerous for prisoners placed there.

### **Deficiencies in the care of prisoners placed in a security cell**

Prisoners described the stay as extremely painful and said they felt treated like animals. There is no running water, so prisoners cannot maintain personal hygiene. Food and drink are pushed in through a floor-level hatch. At times the prison withheld food and drink. The prison's work to prevent isolation-related harm was inadequate, and several prisoners were refused permission to telephone their lawyer.

### **Serious weaknesses in security-cell decisions and continuation reviews**

The prison's decisions often lacked explanations of why placement was strictly necessary, and which less intrusive measures have been tried or assessed first. No proportionality assessment was made for the individual prisoner, making legality hard to verify.

The prison is obliged to reassess placements continuously. Yet intervals of several days passed between written assessments, and none were made at night. The few assessments found were weak and did not consider the statutory criteria, creating a clear risk that prisoners remained in a security cell after the legal basis had lapsed.

In some cases, prisoners stayed in a security cell because they did not co-operate sufficiently with staff. That is not consistent with the law. The prison must work actively to end the measure as soon as possible, bearing in mind that the placement itself may affect a prisoner's ability to co-operate or communicate.

Infrequent and cursory termination assessments led to lengthy placements that were not strictly necessary: more than one-third of all security-cell stays in 2024 lasted over twenty-four hours. The prison did not evaluate its security-cell use adequately, a concern given that a small number of prisoners spent long and repeated periods there.

### **Placements with a particularly high risk of inhuman or degrading treatment**

Repeated and sometimes prolonged placements in a security cell, combined with periods in which prisoners were excluded from association, exposed some individuals to a particularly high risk of inhuman or degrading treatment. The prison did not assess the cumulative effects of this isolation,

nor did it offer mitigating measures. Repeated use of the security cell could itself trigger further negative incidents.

**Need to strengthen health-care record-keeping**

The prison had good routines for notifying health-care personnel of placements, and they usually carried out daily checks without ever being allowed to speak confidentially with the prisoner. Record-keeping, however, showed weaknesses. Short security-cell stays were sometimes omitted, and descriptions of checks performed and of physical conditions were lacking.

### III. Recommendations

#### Decision on security cell placement

1. The prison must ensure that a security cell is used only when the measure is strictly necessary, less intrusive measures have been tried or assessed, and the intervention is proportionate.
2. The prison must document a concrete justification showing that all statutory criteria for using a security cell are met, and the prisoner should be heard.
3. The prison should not use a security cell to prevent or manage self-harm or attempted suicide.

#### Follow-up of prisoners in a security cell

4. The prison should ensure that an individual assessment is always made and documented when handcuffs are used, a body search is performed, or the prisoner is deprived of clothing in connection with placement in a security cell. The same applies to exclusion from association following a security-cell stay.
5. The prison should ensure that pepper spray is never used unless strictly necessary, less intrusive measures have been tried or assessed, and the use is proportionate; these assessments should be documented.
6. The prison should ensure that food and drink are provided in a respectful manner, and as far as possible, without using the floor-level hatch.
7. The prison should ensure that it is possible to maintain personal hygiene in a security cell, whether the prisoner requests it or not.
8. The prison should strengthen follow-up of prisoners in a security cell to prevent isolation-related harm. Follow-up should help end the placement as quickly as possible.
9. The prison should ensure that prisoners can contact their lawyer during the security-cell stay without delay and in full confidentiality.
10. The municipality should ensure that every placement in a security cell is recorded in the medical file, even when no health visit has taken place, and that the record includes concrete information on the physical conditions, the intrusiveness of the measure and any use of force.

#### Assessment of continuation or security cell

11. The prison should ensure that continuous assessments are made of whether the legal conditions for continued placement are met, and that these assessments are documented at least every six hours.
12. The prison must ensure that a security-cell stay ends immediately once the statutory criteria are no longer met.

#### Security-cell placements with a particularly high risk of inhuman or degrading treatment

13. The prison should introduce special measures to prevent lengthy and repeated use of the security cell.

#### Preventing the use of security cells

14. The prison should strengthen its work on evaluating and preventing the use of the security cell and involve prisoners in





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