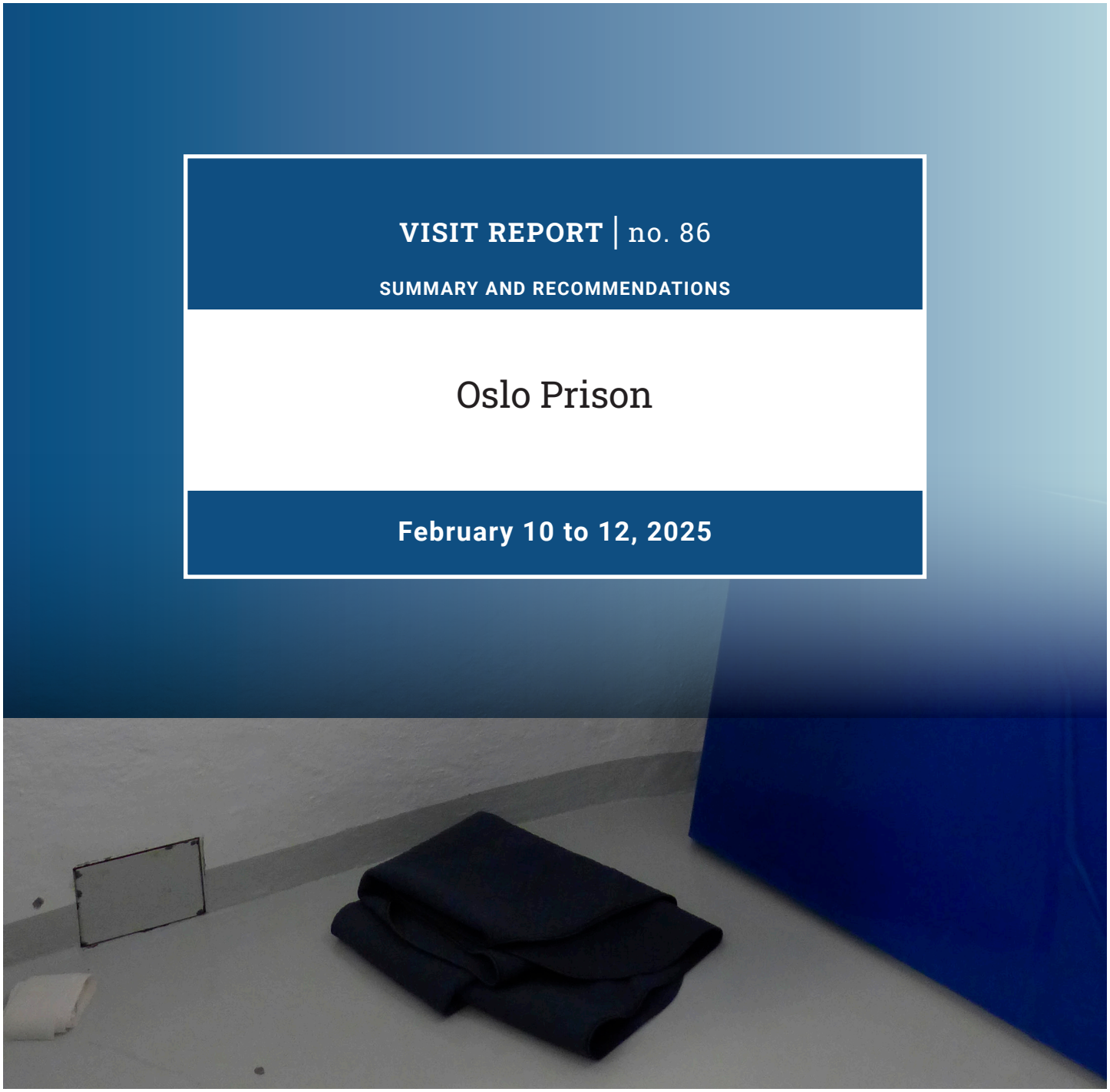
SIVILOMBUDET
Norwegian Parliamentary Ombud



VISIT REPORT | no. 86

SUMMARY AND RECOMMENDATIONS

Oslo Prison

February 10 to 12, 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.[1] The Parliamentary Ombud has established its own national preventive mechanism (NPM) in order to fulfil this mandate.

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

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

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

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

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

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

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

II. Summary

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 the security cells in Oslo Prison. During the period 1 January 2024 – 12 February 2025 the prison made 56 placements in a security cell. Several placements were lengthy, and five prisoners were placed three times or more. On average, a placement lasted more than twenty-four hours.

Particularly burdensome physical conditions

Oslo Prison has three security cells in the basement that are separated from the other units. The design of the cells was burdensome. Prisoners are locked in behind two steel doors, far from other people. The cells are completely stripped, containing only a plastic mattress, a tear-resistant blanket and a hole in the floor that serves as a toilet. Very little daylight enters, and sensory stimulation is almost non-existent.

Deficiencies in the care of prisoners placed in a security cell

Prisoners described the stay as degrading, disgusting and frightening with some saying it triggered earlier traumas. Officers carried out frequent checks but could not open any hatches unless the duty officer was present. It was hard to communicate through closed windows. Food and drink were pushed in through a floor-level hatch. With no running water, prisoners could not maintain personal hygiene. We found the prison working only to a limited extent to prevent isolation damage. Several prisoners were refused permission to telephone their lawyer while in a security cell.

Weaknesses security cell decisions

The prison's decision making concerning the use of a security cell had several weaknesses. The decisions often failed to explain why placement was strictly necessary and which less intrusive measures had been tried or assessed. Most decisions also lacked an assessment of proportionality, making it difficult to verify their legality.

Serious weaknesses in security-cell decisions and continuation reviews

The prison is obliged to reassess placements in security cell continuously, yet documentation was sparse, and no assessments were made at night. We were unable to establish how often the prison actually reviewed placements. In several cases the prison decided in the afternoon that the prisoner would remain until the following morning, contrary to the requirement of continuous review.

Poor documentation meant it was impossible to see whether all statutory conditions had been considered, creating a clear risk that prisoners remained in a security cell after the legal criteria had lapsed.

In several cases the prison required an explanation, an apology or specific behaviour from the prisoner before release. That is not in accordance with the statutory criteria. It is the prison's responsibility to work actively to bring the coercive measure to an end as soon as possible, and there

were also no assessments of whether the measure remained proportionate for the individual prisoner.

Placements with a particularly high risk of inhuman or degrading treatment

There were several placements that entailed a particularly high risk of inhuman or degrading treatment. Examples included a prisoner kept for four days with a broken hand, a prisoner repeatedly deprived of a mattress and forced to lie on concrete overnight, and cases where the same prisoners were placed repeatedly in a security cell. Such placements entailed a particularly high risk of inhuman or degrading treatment, and the prison must do far more to prevent them.

Need to strengthen health-care follow-up in the security cell

The prison systematically failed to notify health-care staff of placements that occurred while the health unit was closed (20:00–07:30). Notification was sent only when the unit reopened, which could be up to twelve hours after the placement. The prison's routine for alerting health-care personnel about security-cell placements was therefore inadequate. To safeguard the prisoner, it is essential that health-care staff attend promptly and assess the prisoner's physical and mental health; the weak notification practice thus entailed a risk of inhuman or degrading treatment.

When health-care personnel were informed, they usually came to the cell and carried out an examination, although we found some exceptions. Prisoners were never allowed to be alone and speak in confidentially with health-care staff. We also identified weaknesses in medical record-keeping: some security-cell stays were not mentioned in the file, and the notes lacked descriptions of how the checks were conducted and of the physical conditions in the cell.

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 spit hoods, tear-gas spray and pepper spray are not used unless strictly necessary, less intrusive measures have been tried or assessed, and the use is proportionate; these assessments should be documented.
5. The prison should ensure that an individual assessment is always made when handcuffs are used, a body search is performed, or clothing is removed in connection with placement in a security cell. 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 the security cells, whether or not the prisoner requests it.
8. The prison should strengthen follow-up of prisoners in a security cell to prevent isolation-related harm and to help end the placement as quickly as possible.
9. The prison should ensure that health-care personnel are notified without delay of every placement in a security cell.
10. The municipality should ensure daily health supervision and follow-up of prisoners placed in a security cell, and that this is documented.
11. The municipality should ensure that every placement in a security cell is recorded in the medical file, including when no health visit has taken place. The documentation should include concrete information on the physical conditions, the intrusiveness of the measure and any use of force.
12. The prison should ensure that prisoners can contact their lawyer during the security-cell stay without delay and in full confidentiality.

Assessment of continuation on security cell

13. 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.

14. The prison must ensure that a security-cell placement ends immediately once the statutory criteria are no longer met.

Security cell placements with particularly high risk

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

Preventing the use of security cells

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

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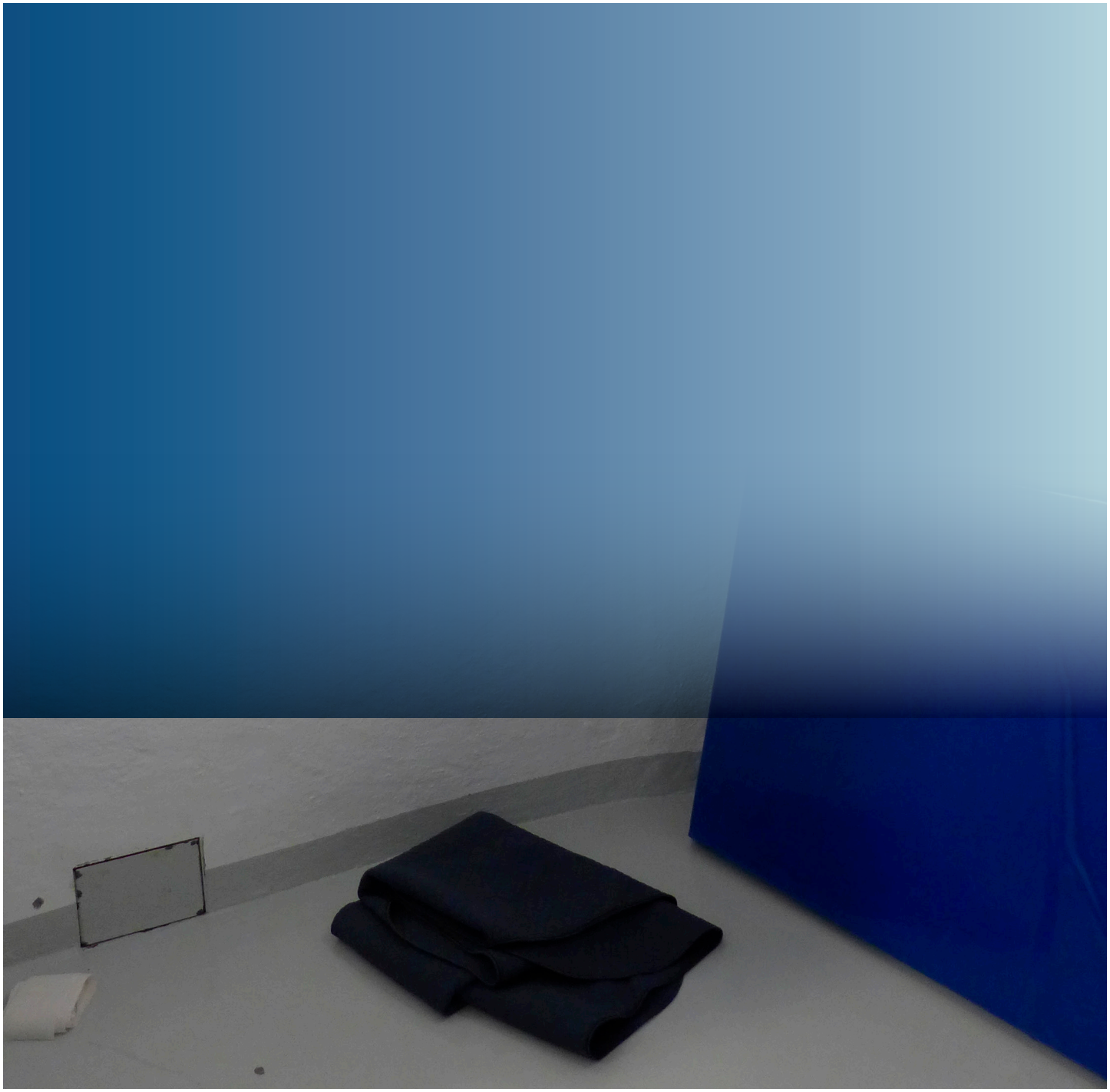

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