SIVILOMBUDET
Norwegian Parliamentary Ombud

**VISIT REPORT** | no. 89

**SUMMARY AND RECOMMENDATIONS**

# Telemark Prison, Skien Unit

**23. April and 25.- 26. May 2025**

National Preventive Mechanism against
Torture and Ill-Treatment

SIVILOMBUDET

Norwegian Parliamentary Ombud
National Preventive Mechanism

# Visit report

## Telemark prison, Skien unit

23. and 26. April and 27. May 2025

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# I. Visit to Telemark prison, Skien unit - examination of the use of security cells

**The Parliamentary Ombud's mandate to prevent torture and inhuman treatment**

Persons who have been deprived of their liberty are vulnerable to violations of the prohibition against torture and inhuman treatment. The Optional Protocol to the UN Convention against Torture requires states to establish a body to prevent torture and other cruel, inhuman or degrading treatment or punishment of persons deprived of their liberty. This task is carried out by the Parliamentary Ombud's National Preventive Mechanism (NPM).[1]

In prisons, the use of security cells and restraint beds are coercive measures that carry a high risk of inhuman or degrading treatment. The NPM has therefore examined the use of these measures in selected prisons.

**The NPM's visit to Telemark prison, Skien unit**

The Parliamentary Ombud's National Preventive Mechanism visited Telemark prison, Skien unit (hereinafter "Skien prison") on 23 April and 26–27 May 2025 to examine the use of security cells.[2] The prison was not notified in advance of the visit.[3] During the visit, the team conducted an inspection of the area where the security cells were located, interviews with prisoners and staff in the prison, and interviews with staff in the municipal health service operating in the prison. During and after the visit, extensive documentation was obtained from the prison and the health service.

We examined the use of security cells and restraint beds in the period from 1 January 2024 to 26 May 2025. During this period, the prison made 49 placements in a security cell and nine placements in a restraint bed.

**Skien prison**

The prison is located in Skien municipality and is a high-security prison for women. At the time of the visit, it had capacity for 65 prisoners. The prison consisted of wings A, B and C. Wing A functioned both as a restrictive and a reception unit with 16 cells. Four of the cells were separated from the rest of the wing in a corridor referred to as "the square" (torget). The cells in "the square" were designed to limit prisoners' opportunities to harm themselves and were used for prisoners who, for various reasons, could not stay in an ordinary cell. The security cells and the restraint bed were located adjacent to wing A, and staff from this unit were responsible for supervising prisoners placed in a security cell or restraint bed.

[1] The Norwegian Parliamentary Ombud Act, Sections 1, 17, 18 and 19.

[2] The visiting team consisted of Helga Fastrup Ervik (Head of Department, lawyer), Karin Fathimath Afeef (Deputy Head of Department, social scientist), Johannes Flisnes Nilsen (Senior Adviser, lawyer), Inga Laupstad (Senior Adviser, lawyer), Tonje Østvold Byhre (Senior Adviser, specialist psychologist), Inger Sønderland (External Expert) and Lars Mathias Enger (Senior Adviser, lawyer).

[3] During the investigation period, the Parliamentary Ombud interrupted one visit day due to a death in the prison. This was done out of consideration for the follow-up of the prisoners and to allow the Correctional Services Supervisory Board to conduct its inspection in accordance with the Regulations on the Supervisory Board for the Correctional Services, Section 4, third paragraph (a), cf. the Execution of Sentences Act, Section 9d.

# II. Summary

**Use of Security Cells and Restraint Beds at Telemark Prison, Skien Unit**

Placement in security cells and the use of restraint beds are coercive measures that expose prisoners to a high risk of inhuman or degrading treatment. The Parliamentary Ombud's National Preventive Mechanism has therefore examined the use of these measures at Telemark Prison, Skien Unit, in the period from 1 January 2024 to 26 May 2025. During this period, the prison recorded 49 placements in security cells and 9 in restraint beds.

**Harsh Physical Conditions**

The prison's two security cells were in a separate corridor. Sensory stimulation inside the cells was very limited, and prisoners were unable to drink water, maintain personal hygiene, or preserve their privacy on their own initiative. The conditions in the cells are extremely onerous for prisoners placed there.

**Reduction in the Use of Security Cells and Restraint Beds**

Following the conversion of Skien Prison into a women's prison on short notice in 2023, 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 the visit, the prison had almost completely ceased using these coercive measures.

Our findings suggest that this change is linked to the prison's systematic efforts to prevent such use of force. These efforts included increasing staff awareness of the legal framework, ensuring more time for dialogue and experience-sharing between shifts, encouraging operational leaders to use alternative approaches, and changing how prisoners were met in stressful or conflict-prone situations. A more structured collaboration had also been established with both primary and specialist healthcare services and external professional environments. Additionally, the prison had hired a specialist psychologist to support staff in handling a demanding work environment.

At the time of the visit, serious incidents in the prison were being resolved without the use of security cells or restraint beds. Access to reinforced cells and relatively good staffing levels appeared to be essential prerequisites for this significant change.

**Risk of Inhuman or Degrading Treatment Prior to the Reduction**

A review of the decisions made by the prison during the first half of the investigation period showed that, in some cases, the justification for placing a prisoner in a security cell was inadequate. A clear weakness was the absence of any assessment of proportionality in these decisions. We also identified shortcomings in the prison's ongoing assessments of the decisions, particularly in longer stays, which posed a risk of violating the prohibition against inhuman or degrading treatment.

Furthermore, there were several concerning aspects regarding the use of restraint beds. Weaknesses were found both in the initial decisions, in ongoing assessments, and in the supervision notes. However, the risk has been significantly reduced as the prison had not used restraint beds for nearly a year.

Prisoners who had been placed in security cells reported that the experience increased their frustration and anger. We found few examples of measures aimed at mitigating the risk of isolation-related harm among prisoners in security cells, and the extent to which staff attempted to establish dialogue with prisoners during their stay varied. There were instances where prisoners were denied the opportunity to contact their lawyer.

A large proportion of prisoners placed in security cells had known vulnerabilities, such as young age, substance abuse issues, and repeated suicide attempts. Nevertheless, the healthcare service had not conducted daily medical supervision of these prisoners. Additional weaknesses were found in medical record-keeping, including instances where a prisoner's placement in a security cell was not documented in their health records.

**Maintaining the Positive Change Over Time**

The reduction in the use of security cells and restraint beds at the prison is highly positive. In the report, the Parliamentary Ombud emphasizes that this positive development must be sustained through continuous and targeted efforts to ensure that the improvements are maintained over time. The findings described in the report, along with the recommendations provided, will be essential in supporting this work.

# III. Recommendations

**Use of reinforced cells**

1. The prison should continue its comprehensive efforts to prevent the use of coercion and to develop a culture that promotes the least possible use of coercive measures, in cooperation with the health services.

2. The prison should ensure that decisions on exclusion clearly describe how the exclusion is to be implemented, and that any additional restrictions and security measures are documented.

**Decision on placement in a security cell**

3. The prison must document a concrete justification showing that all statutory criteria for using a security cell are met. The prisoner should be given an opportunity to be heard.

4. The prison should continue its efforts to prevent the use of security cells to avert or manage self-harm or suicide attempts.

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

5. The prison should ensure that an individual assessment is always made—and documented—when prisoners are strip-searched or deprived of clothing in connection with placement in a security cell.

6. The prison should ensure that prisoners in a security cell are provided with food and drink 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, regardless of whether the prisoner requests it or not.

8. The prison should strengthen the follow-up of prisoners placed in a security cell to prevent isolation-related harm. The follow-up should help ensure that the placement ends as soon as possible.

9. The prison should ensure that prisoners are able to contact a lawyer during placement in a security cell without delay and in full confidentiality.

10. The municipality should ensure daily supervision and follow-up of prisoners placed in a security cell, and that this is documented.

11. The municipality should ensure that placement in a security cell is recorded in the medical file, even in cases where the health service has not carried out supervision. The documentation should include concrete information about the specific physical conditions in the security cell, the intrusiveness of the measure, and any use of force in connection with the placement.

**Ongoing assessment**

12. The prison must ensure that ongoing assessments are made of whether the legal conditions for continued placement in a security cell are met. These ongoing assessments should be documented at least every six hours.

13. The prison must ensure that security-cell placements are terminated immediately when the legal conditions are no longer met.

**Use of restraint bed**

14. The prison must document a concrete justification showing that all statutory criteria for using a restraint bed are met.

15. The prison must ensure that ongoing assessments are made of whether the legal conditions for continued placement in a restraint bed are met. The prison should document the ongoing assessments.

16. The prison should ensure that the care and follow-up of prisoners placed in a restraint bed are properly recorded in the medical file.

17. The municipality should ensure that health personnel carry out supervision of prisoners who are, or have been, placed in a restraint bed as soon as possible, and that this is documented.

18. The municipality should ensure that placement in a restraint bed is recorded in the medical file, even in cases where the health service has not carried out supervision. The documentation should include concrete information about the specific physical conditions, the intrusiveness of the measure, and any use of force in connection with the placement.

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