



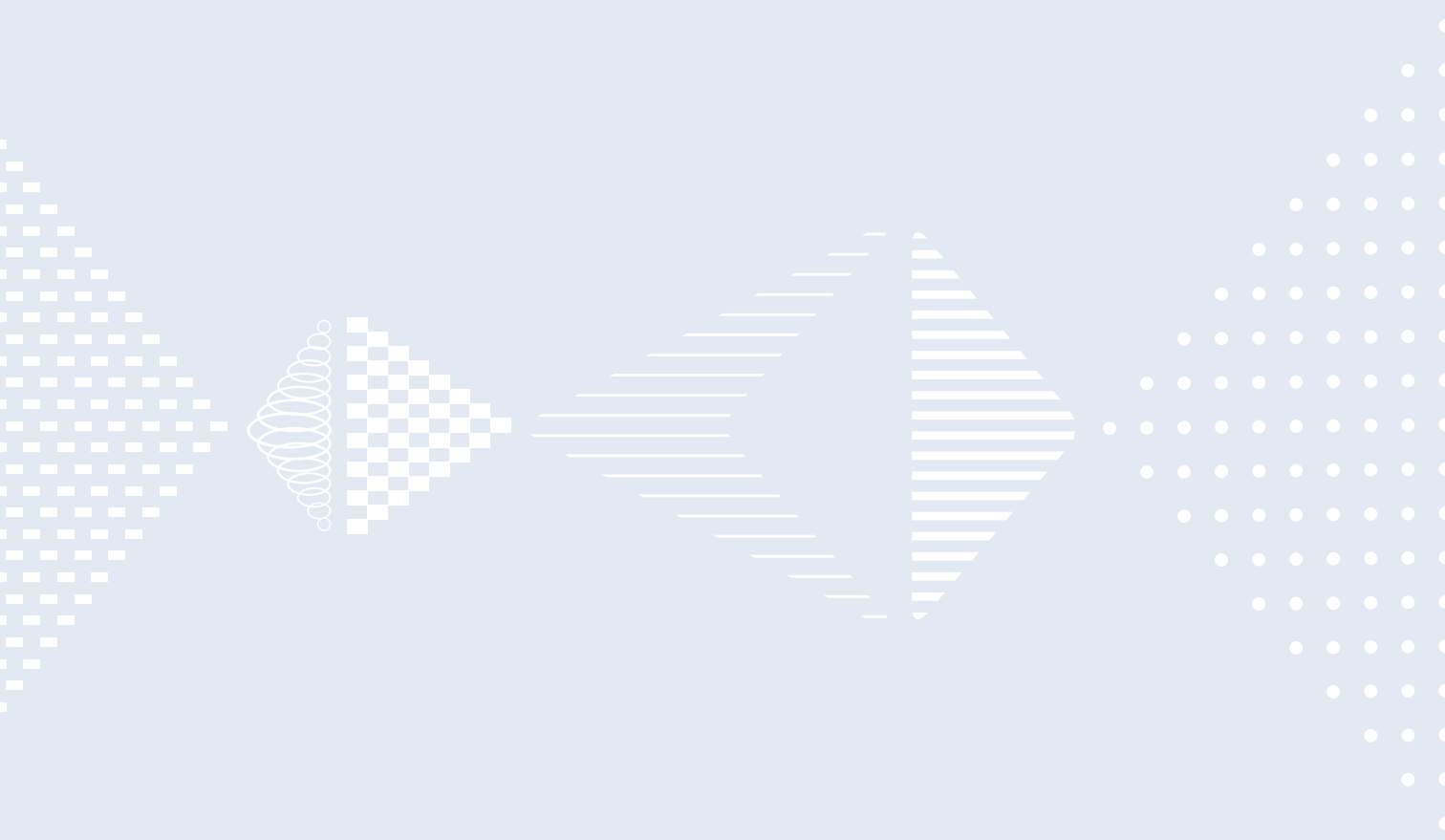
# SIVILOMBUDET

Norwegian Parliamentary Ombud

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

## ANNUAL REPORT 2025





This English translation has been produced with the assistance of AI, and subsequently edited and verified by the Norwegian Parliamentary Ombud.

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## The year at a glance

In its eleventh year, the Norwegian National Preventive Mechanism (NPM) continued its efforts to identify risks of inhuman or degrading treatment, document harmful practices and promote sustainable improvements in places of detention.

Throughout 2025, we prioritised high-security prisons through visits, dialogue and systematic follow-up. Towards the end of the year, we also initiated investigations in the field of mental healthcare and carried out visits to psychiatric acute wards at two hospitals.

### **Special report to the Storting on extensive cell confinement and de facto isolation**

In 2025, the Parliamentary Ombud submitted a special report to the Storting on extensive cell confinement and de facto isolation. Six years earlier, in 2019, the Ombud had already drawn the Storting's attention to extensive use of solitary confinement and lack of meaningful human contact in Norwegian prisons.

The 2019 special report contributed to increased awareness within the correctional services that solitary confinement constitutes an intrusive and harmful measure and that too many prisoners were locked in their cells alone for large parts of the day. In the years that followed, several measures were implemented to reduce the use of solitary confinement and strengthen supervision of prisoners in solitary confinement.

However, the Parliamentary Ombud's investigations of ten high-security prisons in 2023 and 2024 indicate that the challenges related to prisoners being locked in or effectively isolated in their cells remain very serious. The findings show that a significant 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.

In several prisons, the Parliamentary Ombud documented that prisoners were locked in their cells for as much as 19–22 hours per day without this being due to their own behaviour and without formal decisions, in some cases even exceeding 22 hours. When this results from general prison conditions, a significant number of prisoners risk being subjected to inhuman or degrading treatment and other human rights violations.

### **Legislative proposal following up the special report**

The 2025 special report to the Storting has been followed up through the Ombud's presentation to the Standing Committee on Scrutiny and Constitutional Affairs, as well as meetings with the Ministry of Justice and Public Security. An important step forward was the Government's introduction in 2025 of a legislative proposal to amend the Execution of Sentences Act, with the aim of reducing the use of isolation in prisons. On many key points, the proposal follows up our recommendations from the special reports and from thematic reports.

However, during the oral hearing in the Standing Committee on Justice, the Parliamentary Ombud emphasised the seriousness of the fact that developments are moving in the wrong direction, noting that many prisoners still spend large parts of the day alone in their cells. The proposal still permits extensive and harmful isolation of prisoners, and the Ombud has put forward several suggestions for improvement.



Parliamentary Ombud Hanne Harlem presenting the special report to the President of the Storting, Masud Gharahkhani. Photo: The Storting

### Security cells

This year we have focused our investigations primarily 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 human rights prohibition against inhuman and degrading treatment. The use of such measures is particularly serious when minors are affected. In the youth prison visited in 2025, minors were placed in security cells on the basis of incorrect legal thresholds, despite the very high protection standard that applies to children deprived of their liberty.

These findings highlight the importance of ensuring that the rights and best interests of children are effectively safeguarded in all detention settings.

### Mechanical constraints in mental health care

Following serious findings in previous inspections, we initiated a thematic investigation into the use of mechanical restraints in mental health care.

Mechanical restraints are a highly intrusive measure and entail a significant risk of violations of patients' fundamental rights. This work will continue in 2026.

The Norwegian NPM remains committed to strengthening protection against ill-treatment and to promoting conditions of detention that respect human dignity and fundamental human rights.

Our findings in the past year demonstrate the need for sustained and systematic preventive efforts. While structural challenges related to resources, staffing and capacity continue to affect prison conditions, experience also shows that targeted measures, strengthened competence and closer cooperation between services can lead to meaningful and lasting improvements.

**Hanne Harlem**  
Parliamentary Ombud

## Our mandate

The prohibition on torture and other cruel, inhuman or degrading treatment or punishment is established in the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture).

The same prohibition is also embodied in the UN International Covenant on Civil and Political Rights (Article 7), the UN Convention on the Rights of the Child (Article 37), the UN Convention on the Rights of Persons with Disabilities (Article 15) and the European Convention on Human Rights (Article 3). Norway has ratified all of these conventions.

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

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

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

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

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

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

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

1 Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, articles 17-23.

2 Section 1, 17, 18 and 19 of the Norwegian Parliamentary Ombud Act.

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

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

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



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

## Our work in numbers

Total  
**9**  
 completed  
 visits in 2025



**5** visits to prisons

**1** visit to a youth detention facility

**1** visit to an immigration  
detention centre

**2** visits to hospitals

**21**

interviews with  
prisoners

**6**

interviews with patients in  
mental health services

**11**

interviews with prisoners at the  
immigration detention centre

**106**

interviews with  
prison staff

**52**

interviews with staff in  
mental health services

**27**

interviews with staff at the  
immigration detention centre

**8**

published visit  
reports

**1**

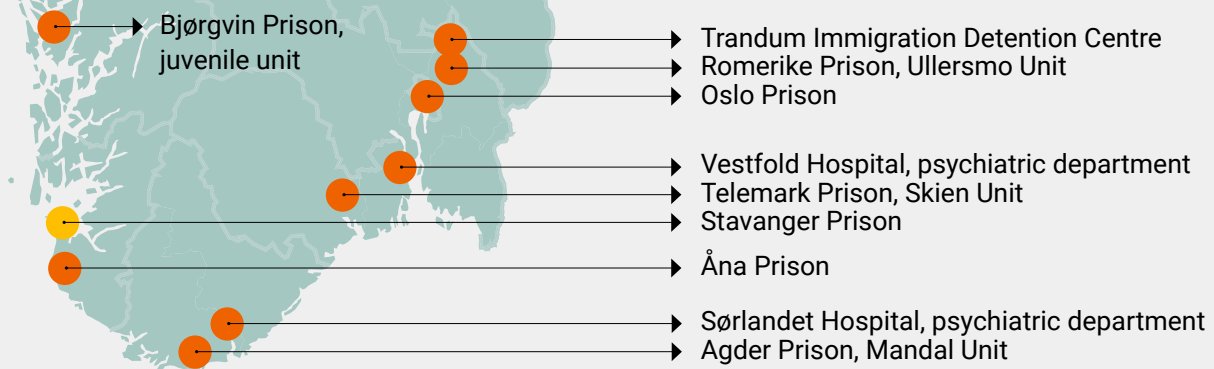
special report to  
the Storting

**3**

thematic reports

## Visits and visit reports in 2025

- places visited in 2024, visit report published in 2025
- places visited in 2025



## Visits to prisons in 2025

The core task of the National Preventive Mechanism is to visit places where people are, or may be, deprived of their liberty. Our aim is to reduce the risk of torture or other inhuman or degrading treatment.

In 2025, the NPM continued to prioritise high-security prisons. Prisons are at the core of the NPM's mandate. During the year we visited five high-security prisons, and also one youth detention facility, two hospitals and one immigration centre. A visit process normally consists of three stages: the collection of relevant documentation in advance, the on-site visit itself, which usually lasts between two and four days, and the collection of additional information afterwards. Based on this, the NPM prepares a visit report containing analyses and recommendations addressed to the

institution. The report is followed up through a written dialogue with the institution concerned.

This year, we carried out thematic visits focusing on the use of security cells in prisons. These are highly intrusive coercive measures and entail a high risk of inhuman or degrading treatment.

High-security prisons have been prioritised following the NPM's findings of critical and life-threatening conditions at Bredtveit Prison in 2023. Since then, we have conducted a total of



The Parliamentary Ombud's National Preventive Mechanism. From the left: Daniel Haavorsen, Solveig Igesund, Inga Tollefsen Laupstad, Helga Fastrup Ervik, Mari Dahl Schlanbusch, Lars Mathias Enger, Hanne Harlem, Audun Solli, Tonje Østvold Byhre, Ida Giske, Johannes Flisnes Nilsen. Photo: Hanna Johre



The NPM during a visit to Agder Prison, Mandal Unit. Photo: The Parliamentary Ombud

fourteen visits to adult prisons: four in 2023, five in 2024 and five in 2025.

The prisons visited in 2025 were Agder Prison (Mandal Unit), Oslo Prison, Telemark Prison (Skien Unit), Romerike Prison (Ullersmo Unit) and Åna Prison.

The findings from these visits have been summarised in a thematic report on the use of security cells, which was published in December 2025.

## Selected findings

### › *The design of security cells*

One of the main findings from our thematic examination of security cells is that the physical design of the cells in itself constitutes a risk of violating the prohibition against inhuman and degrading treatment under international human rights law.

## What is a security cell?

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. Security cells differ from other forms of solitary confinement in that the design of the cell provides extremely limited sensory stimulation and significantly restricts the prisoner's ability to meet basic personal needs.

### › *Use of security cells in cases of 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. Some prisoners were placed directly in security cells after being rescued from severe suicide attempts, without any indication that the prison sought to remain present, offer supportive conversations or involve the health services.

Placing a person who has just attempted suicide alone in a bare concrete cell is highly problematic and may intensify feelings of despair. This entails a high risk of human rights violations. 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 Parliamentary Ombud 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.

### › *Prolonged security cell placements*

We uncovered several cases involving prolonged and repeated stays in security cells. Many prisoners were held in solitary confinement in security cells for more than 24 hours, and some for several consecutive days. The longest recorded stay lasted 13 days. It is problematic that prisoners are isolated for such long periods under highly intrusive conditions.



The Parliamentary Ombud measuring the size of a security cell. Photo: The Parliamentary Ombud

The purpose of the isolation has relevance to the permissible duration of the placement. The CPT has accepted short-term placement in special cells to prevent immediate harm to the prisoner or others, but has stressed that the placement should be measured in minutes rather than hours. Our findings show that Norwegian prisons apply a practice that allows for stays far exceeding this standard.

In all prisons visited, assessments of whether the placement could be terminated were carried out too infrequently, and the justifications were often highly inadequate. As a result, many prisoners remained in security cells for longer than permitted under the law.



Security cell at Romerike Prison, Ullersmo Unit. Photo: The Parliamentary Ombud

Decisions were rarely reassessed during the night. Prisoners placed in the afternoon were therefore often kept until the following morning, even when the situation changed. In some cases, prisoners remained in security cells for several days.

For prisoners who were placed in security cells repeatedly, there were no assessments of how this affected their mental health or of the cumulative burden. At Åna Prison and Romerike Prison, Ullersmo Unit, prisoners were repeatedly placed in security cells without any evaluation of the overall strain. At Oslo Prison, several justifications appeared standardised and insufficiently individualised. At Telemark Prison, Skien Unit, considerations of proportionality and the severity of the intervention were not addressed in the decisions. At Agder Prison, Mandal Unit, some placements were maintained until prisoners had “calmed down” or “apologised”, a practice that is not in accordance with legal requirements.

#### › **Use of disproportionate force**

Our findings reveal particularly serious cases of ill-treatment. This included prisoners who had

remained in security cells for several days, incidents involving the use of handcuffs and pepper spray inside the security cell, and cases where prisoners were deprived of mattresses for several days. The Parliamentary Ombud concludes that these cases appear to constitute breaches of the prohibition against inhuman or degrading treatment.

#### › **Insufficient healthcare follow-up in security cells**

During visits in 2025, the Parliamentary Ombud found that healthcare follow-up of prisoners placed in security cells was often inadequate and, in some cases, entirely absent. This concerned access to confidential communication, frequency of medical supervision and documentation in health records.

At Romerike Prison, Ullersmo Unit, healthcare personnel never spoke confidentially with prisoners during security cell placements. Several placements were also not documented in medical records, making it difficult to verify whether prisoners' healthcare needs were addressed.



Åna Prison. Photo: The Parliamentary Ombud

At Oslo Prison, medical supervision was often reduced to brief visual observations through a door or window, without systematic assessments of mental health status. Documentation was weak and insufficient to provide an overview of prisoners' needs.

At Åna Prison, prisoners were usually examined by healthcare personnel upon placement in a security cell, but follow-up during the stay was sporadic. Several prisoners remained in security cells for days without further medical contact.

At Telemark Prison, Skien Unit, it was documented that healthcare personnel did not always conduct supervision of prisoners placed in security cells, and that the supervision carried out was brief and lacked confidential communication. Medical record-keeping was deficient, and it was often unclear whether independent medical assessments had been conducted.

The situation at Agder Prison, Mandal Unit, appears particularly problematic. In seven out of sixteen placements, no medical supervision was carried out, including two placements lasting more than 60 hours. One prisoner who was placed in a security

cell on five occasions received medical supervision only once. Medical records did not provide a complete overview of placements, meaning that healthcare documentation obligations were not fulfilled.

Lack of healthcare follow-up means that prisoners placed in security cells do not receive the protection to which they are entitled. When healthcare services fail to establish confidential contact or conduct systematic follow-up, opportunities to detect suicide risk, mental health crises or isolation-related harm are lost. This increases the risk that security cell placements become more harmful than necessary.

#### › **Lack of preventive work**

Our investigations revealed deficiencies in prisons' knowledge of the regulatory framework. The same applies to conflict prevention and the care of prisoners in crisis who are particularly vulnerable to isolation-related harm.

The thematic report on security cells also highlights shortcomings in how prisons learn from previous incidents. Apart from Telemark Prison, Skien Unit, the prisons visited in 2025 made limited systematic efforts to prevent the use of security cells. Placements were largely treated as isolated incidents, without evaluations or learning measures aimed at reducing the need for future placements.

At Agder Prison, Mandal Unit, no evaluations or internal reviews were conducted following prolonged or repeated placements. At Åna Prison and Romerike Prison, Ullersmo Unit, prisoners were repeatedly placed in security cells without any assessment of cumulative burden or consideration of alternative measures. Oslo Prison lacked similar routines, and placements were often continued without any plan for reintegration into communal regimes. At Telemark Prison, Skien Unit, prisoners' own views of the incidents and possible placements were not addressed in any of the 48 decisions reviewed by the Parliamentary Ombud.

### Telemark Prison, Skien Unit – reduced use of security cells and restraint beds

After Telemark Prison, Skien Unit was rapidly converted into a women's prison in 2023, the prison experienced a period of extensive use of both security cells and restraint beds. During 2024 and 2025, the prison implemented targeted measures to reduce the use of such coercive interventions.

The prison strengthened staff knowledge of the legal framework, facilitated increased dialogue and experience-sharing between shifts, and encouraged duty managers to consider alternative solutions in challenging situations. Closer cooperation was established with prison health-care services, specialist healthcare services and

external professional environments. The prison also recruited a specialist psychologist to provide follow-up support to staff after demanding incidents.

These changes have had a clear effect. Over the past year, the prison has almost entirely ceased using security cells and restraint beds. The Preventive Unit considers this an important example of how systematic work, increased competence and strengthened follow-up can significantly reduce the need for highly intrusive coercive measures.

The absence of preventive measures increases the risk of prolonged and repeated placements in security cells. Where prisons fail to review their own practices or actively seek less intrusive alternatives, this

contributes to the continued use of security cells and to their gradual normalisation as a routine measure.



Staff from the NPM conduct an inspection of a security cell. Photo: The Parliamentary Ombud



## Prisoners' quotes on security cells

**"I was told that if I felt low or wanted to harm myself – which I have a history of – I should contact staff. But when I did, they put me in a security cell instead."**

**"You become more angry. More frustrated. It doesn't help at all. Either you just get much worse. Or you store all that anger and then it explodes two days later. That's not good. It messes with your head."**

**"You're just supposed to move on and not think about it. But it's dirty and disgusting. You have to go to the toilet on the floor and can't flush yourself. Time moves very slowly. There's no contact with staff. They just come down and check that you're alive. They don't talk to you."**

**"It's completely different down there compared to a regular cell. You feel like an animal. It's torture."**

What made them let you out?

**"That I apologised. I asked one of the officers who brought me food what it would take for me to get out. He said I had to apologise, and then he left. A couple of hours later, I apologised."**

Were you able to wash your hands?

**"No. That's the worst part. You go to the toilet and then eat food with your hands afterwards. That's also part of feeling like an animal. You feel degraded no matter what."**

Do you know why it ended?

**"No, I don't know. They probably just saw that I was calm. But I was calm the whole time, so there was no point in keeping me there."**

**"There's always been a threat. If you don't behave now, if you don't watch yourself, you'll be put in a security cell."**



# Intrusive and degrading physical conditions in security cells

Placement in a security cell is among the most intrusive measures that can be used in prisons. In 2025, the Parliamentary Ombud examined the physical conditions of security cells in five high-security prisons.

## Stripped environment and lack of control

Security cells are small rooms, often located in basement areas, and typically measure between five and eight square metres. They are constructed in concrete, with smooth, usually grey-toned walls and a toilet consisting of a hole in the floor. In almost all cases, the windows are small and placed high on the wall, and some are frosted. Furnishings usually consist of a plastic mattress and a tear-resistant blanket. The CPT recommends a minimum cell size of six square metres and a ceiling height of 2.5 metres – a standard that neither Åna Prison nor Romerike Prison, Ullersmo Unit, meets.

In security cells, prisoners have minimal control and are deprived of all privacy. Officers must be able to observe prisoners at all times. There is no running water available for personal use, and flushing of the toilet is controlled by staff outside the cell. This makes it difficult to maintain basic hygiene. Prisoners are entirely dependent on prison staff for even the most fundamental needs.

In most prisons, food was routinely passed through a hatch at the bottom of the door, often near the hole in the floor used as a toilet. Several prisoners reported that they avoided eating in the cell because it felt unhygienic to eat next to an open toilet hole.



Security cell in Åna Prison.  
Photo: The Parliamentary Ombud

The only way prisoners can contact staff outside routine checks is by pressing a silent call button. The button provides no confirmation that the signal has been registered, creating uncertainty for prisoners. In addition, acoustic conditions in the cells are poor. Both prisoners and staff reported that they often have to shout through plexiglass windows or narrow inspection hatches in the door to communicate. This makes it difficult to hold meaningful dialogue about prisoners' needs or the termination of placements.

### **Sensory deprivation and loss of time perception**

Windows in security cells often provide little real view or daylight. Very limited sensory stimulation is available inside the cell, and several prisoners described the experience as "losing touch with reality". The lack of sensory input and predictability is known to increase the risk of isolation-related harm.

This burden is further intensified by uncertainty about how long the placement will last. Prisoners may experience anxiety, restlessness, concentration difficulties or depression after a short period of time. For some, placements trigger the re-experiencing of previous trauma, while others develop panic reactions, intrusive thoughts or worsening of existing mental health conditions. Taken together, the Parliamentary Ombud's findings show that the physical design of security cells in itself entails a risk of inhuman and degrading treatment.

### **Need for change**

International human rights bodies, including the European Court of Human Rights and the CPT, have emphasised that the design and use of security cells must be assessed in light of the prohibition against inhuman or degrading treatment. Key factors include cell size, access to daylight and sensory stimulation, opportunities for hygiene, and the duration of placements.

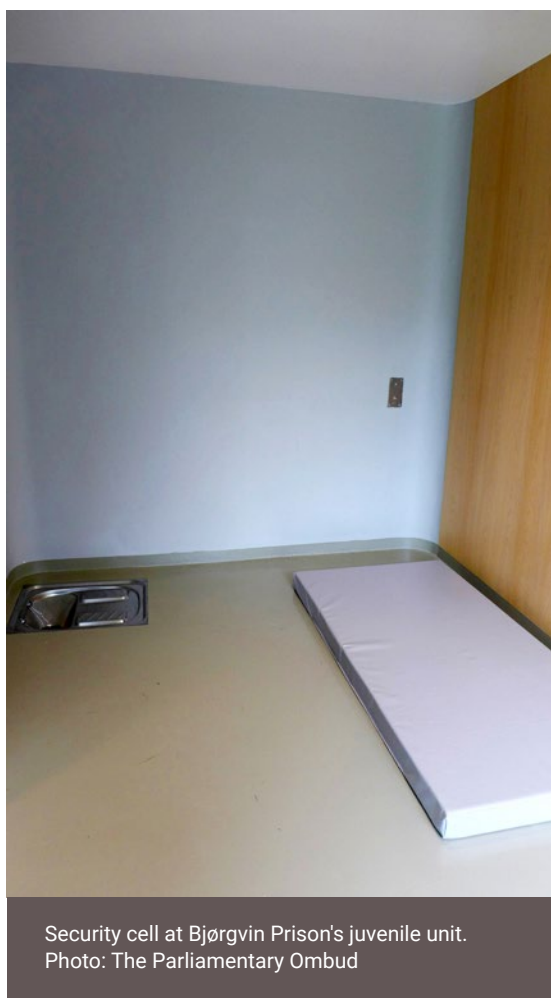
Although some newer prisons, such as Agder Prison, Mandal Unit, provide improved lighting conditions and external views, the Parliamentary Ombud's overall assessment is that security cells still deprive prisoners of any meaningful control over their own lives beyond what is strictly necessary to fulfil the purpose of placement. At the same time, the risk of health-related harm increases.

At a minimum, security cells should provide access to daylight, opportunities for hygiene, water and food in a dignified and humane manner, and a physical design that reduces the risk of disorientation and isolation-related harm.

To mitigate the harmful effects of physical conditions, prisoners placed in security cells must be closely monitored by both prison staff and health-care personnel. Active supervision is essential to safeguard safety, health and dignity. Placement in security cells must be strictly necessary and as short as possible. Each hour without meaningful human contact increases the risk of health-related harm.

# Risk of unlawful use of coercion in youth prison

In the spring of 2025, the Parliamentary Ombud visited the juvenile unit at Bjørgvin Prison, and examined the use of security cells over a 15-month period. The visit report revealed a high risk of unlawful use of coercive measures.



Security cell at Bjørgvin Prison's juvenile unit.  
Photo: The Parliamentary Ombud

Under the Norwegian Execution of Sentences Act, the threshold for placing minors in security cells is very high. Such placement may only occur when it is “imperatively necessary”. In almost all of the written decisions reviewed by the Parliamentary Ombud, the juvenile unit *Ungdomsenhet Vest* applied the less stringent legal threshold applicable to adult prisoners.

It is highly problematic that the prison placed minors in security cells based on incorrect legal criteria. This significantly increases the risk that the decisions were unlawful. Several decisions also lacked any assessment of the best interests of the child.

## Degrading and inhuman treatment

Bjørgvin Prison's juvenile unit is one of three youth detention facilities in Norway and has a total capacity of four places.

The Parliamentary Ombud identified several highly concerning practices in the use of security cells. Among other findings, the prison applied an unnecessarily strict practice whereby prisoners were systematically deprived of their own clothing. One particularly alarming case involved a prisoner who was deprived of clothing, a tear-resistant blanket and a mattress, and was left lying naked directly on the concrete floor for more than 14 hours

overnight. The prisoner was held in the security cell for more than 18 hours in total.

This incident appears to constitute a violation of the prohibition against inhuman and degrading treatment.

### **Risk of isolation-related harm**

Solitary confinement in security cells represents the most intrusive coercive measure that can be used against minors in prison and entails a particularly high risk of isolation-related harm. This risk is even greater for children. The Norwegian correctional services and the youth prisons therefore carry a special responsibility. The UN Special Rapporteur on Torture has emphasised that even short periods of deprivation of freedom may undermine a child's mental and physical health and negatively affect cognitive development. The risk increases when the child is isolated. The longer the solitary confinement lasts, the greater the strain and potential for harm. The Parliamentary Ombud's report on the youth prison in Bergen documents several placements in a security cell lasting more than 15 hours.

In security cells, the toilet consists of a hole in the floor, and a plastic mattress is the only furnishing. There is no access to water, and flushing must be carried out by prison staff from outside the cell.

The Parliamentary Ombud also found incidents where the children placed in security cells had been denied both water and access to legal counsel. That minors in youth prisons are subjected to such conditions for hours on end, without knowing how long the placement will last, is unacceptable and warrants strong criticism.

### **Children behind prison walls**

Most minors held in Norwegian prisons have not been convicted. A significant proportion are held in pre-trial detention while their cases are under investigation.

We also know that many come from backgrounds involving exposure to violence. When young people with such experiences are isolated in security cells, the risk of psychological harm increases.

### **Follow-up of findings**

The findings from the juvenile detention unit received extensive media attention. Following publication of the report, Minister of Justice Astri Aas-Hansen stated that she viewed the conditions uncovered by the Parliamentary Ombud as very problematic. Both in media statements and in responses to written questions from members of Parliament, the Minister committed to follow-up measures. She requested that the Directorate of the Norwegian Correctional Service provide a comprehensive account of the use of coercive measures at all three youth prison units in Norway.

As part of the follow-up process, the Parliamentary Ombud also held meetings with the Directorate of the Norwegian Correctional Service and the Western Region of the Correctional Service to present and discuss the findings.

## The prisons' follow-up of visits

After visit reports are published, prisons are given approximately three months to submit written feedback to the Parliamentary Ombud describing how they are following up the recommendations. In 2025, we received feedback from nine prisons. Five of these prisons were visited in 2025. The juvenile unit at Bjørgvin Prison and Telemark Prison will submit their responses in 2026.

Several prisons have implemented measures in response to the NPM's recommendations. Many of these measures are similar across institutions, including strengthened cooperation with healthcare services, increased time out of cell, expanded activity programs and improved routines for monitoring solitary confinement and coercive measures. In addition, some prisons have implemented measures tailored to local conditions.

Based on the written feedback, the Parliamentary Ombud assesses whether the measures implemented are satisfactory.

### Measures implemented by several prisons

- › Revised instructions on the use of security cells to ensure reassessment of placements every six hours.
- › Establishment of regular coordination meetings between prisons, municipal health services and specialist health services.
- › Changes to shift patterns and staffing plans to increase time spent out of the cell and communal activity.
- › Development of low-threshold services and new courses to strengthen daily activity programs.
- › Recruitment of environmental therapists, workshop instructors and contact officers to improve follow-up of prisoners .
- › Introduction of new routines for the use of interpreters, documentation and quality assurance of decisions.

- › Revision of routines for the use of security cells to ensure more dignified conditions and improved justification of decisions.
- › Staff training in suicide prevention (VIVAT) and the management of disciplinary measures.
- › Establishment of contact with voluntary organisations and support services such as Kirkens SOS to provide additional support to prisoners .

### Examples of measures implemented in individual prisons

#### Åna Prison

- › Revised instructions on the use of personal clothing in security cells, establishing that prisoners should as a general rule be offered their own clothes or prison clothing.
- › Installation of new door hatches to enable distribution of food, drinks and medication.

#### Oslo Prison

- › Introduction of routines ensuring that food and drink are delivered at the door rather than through floor hatches when security conditions allow.
- › Strengthened internal control by requiring security inspectors to systematically review all security cell decisions before archiving.

#### Agder Prison, Mandal Unit

- › Implementation of annual training in the legal framework governing the use of security cells.
- › Measures to ensure that prisoners placed in security cells are offered food every four hours.

#### Romerike Prison, Ullersmo Unit

- › Establishment of a dedicated unit for prisoners assessed as presenting particularly high risk, aimed at improving monitoring and preventing repeated placements in security cells.

**Stavanger Prison**

- › A youth liaison officer has been appointed to strengthen follow-up of prisoners under the age of 25.
- › Evening activity programs have been introduced in restrictive units, and cooperation with the Red Cross and “Music in Prison” has been expanded.

**Indre Østfold Prison, Eidsberg Unit**

- › A new unit for minors has been established, staffed with dedicated youth officers and supported by an expanded youth team.
- › A supervision function related to solitary confinement and an activation team have been introduced to follow up isolated prisoners and to document measures in the case management system.

**Ålesund Prison**

- › Low-threshold activity offers have been introduced in the communal loft area, along with new courses such as barista training, anger management and the “cooking club” focusing on food preparation and nutrition guidance.
- › The outdoor exercise yard has been improved through the installation of roofing, planting and benches, and a direct contact line to Kirkens SOS has been established for prisoners .

**Ringerike Prison**

- › Plans have been developed for a new activity building and outdoor exercise balconies to increase access to activities and fresh air.
- › Follow-up conversations with prisoners after the use of solitary confinement and coercive measures have been introduced, aimed at learning and assessment of possible changes in practice.
- › Future action plans on suicide prevention are to include increased contact with family and friends as a compensatory measure.

**Trondheim Prison and Preventive Detention Facility, Nermarka Unit**

- › Extensive refurbishment of Building E, a communal unit, has been planned to ensure toilets in all cells and larger common areas.
- › The preventive detention unit has been strengthened through the recruitment of environmental therapists, the appointment of a new unit manager and the introduction of monthly professional supervision by a psychologist.

**Demanding resource situation**

Prisons report that tight budgets and low staffing levels represent the main obstacles to implementing the Parliamentary Ombud’s recommendations. Several institutions also report that the prisoner population has become more demanding, with an increasing number of prisoners experiencing severe mental health problems. This, in turn, contributes to increased use of intrusive coercive measures and solitary confinement.

Many prisons describe daily operations as characterised by difficult trade-offs between security considerations and meaningful human contact within strict financial frameworks.

**Ana Prison** reports that a large proportion of the prisoner population suffers from mental health problems and faces an elevated risk of self-harm and suicide, making this group particularly vulnerable. The prison emphasises that adequate follow-up of these prisoners requires targeted and sustained efforts.

**Oslo Prison** highlights that framework conditions such as buildings, staffing levels, budgets and regulatory requirements significantly affect the prison’s ability to fulfil its mandate and achieve quality objectives.

**“We have not achieved our objectives, and we cannot achieve the quality goals alone. Buildings, staffing, budgets and occupancy levels are all decisive factors in this context. We are operating under a partially outdated regulatory framework.”**

(Letter from Oslo Prison to the Parliamentary Ombud, 20 October 2025)

**Romerike Prison** reports that staffing challenges combined with increased documentation and case-processing requirements reduce the prison’s capacity to follow up the Parliamentary Ombud’s recommendations.

**Stavanger Prison** points to persistent staffing shortages that limit the time available for direct follow-up of prisoners .

**“We are currently experiencing an increase in administrative requirements, which may affect presence and other tasks related to interpersonal interaction.”**

(Letter from Stavanger Prison to the Parliamentary Ombud, 19 August 2025)

**Indre Østfold Prison, Eidsberg Unit**, reports long-standing recruitment and staffing challenges. The prison highlights that the increase in the number of minor prisoners has required additional resources and made it difficult to maintain ordinary operations.

**“We have observed that a youth team consisting of five staff members has not been sufficient to provide adequate follow-up for up to three minors.”**

(Letter from Indre Østfold Prison, Eidsberg Unit, 23 April 2025)

**Ålesund Prison** reports that both staffing levels and building conditions impose clear limitations on service provision. The prison is located in a protected building dating from 1864, which restricts opportunities to expand healthcare facilities or activity areas.

#### **Trondheim Prison and Preventive Detention**

**Facility** report significant changes in the prisoner population in recent years, including a higher proportion of prisoners with severe mental health problems, elevated risk of violence and extensive follow-up needs. This development places pressure on security arrangements and contributes to increased use of solitary confinement and coercive measures.

### Request to the Directorate of the Norwegian Correctional Service

In the follow-up of the visit report, Ringerike Prison points to a deterioration in conditions resulting from planned reductions in baseline staffing levels. Staffing levels are already affecting daily activity provision and security, and the physical condition of the prison buildings further aggravates the situation.

On this basis, the Parliamentary Ombud has decided not to close the case. The Directorate of the Norwegian Correctional Service has been asked to explain how the situation at Ringerike Prison will be followed up in order to prevent systematic violations of prisoners' fundamental rights. Follow-up of the case will continue in 2026

**“It is clear that the financial situation at Ringerike Prison has for a prolonged period been, and continues to be, very challenging, and that this has also had consequences for staffing levels at the prison. The financial situation has led to a process in which we have found it necessary to further reduce staffing levels.”**

(Letter from Ringerike Prison to the Parliamentary Ombud, 31 July 2025)



Ringerike prison. Photo: The Parliamentary Ombud

## **Prison healthcare services' follow-up of our recommendations**

### ***Improved and more rapid health screening***

Healthcare services have strengthened routines to ensure that prisoners receive systematic health screening upon admission, including assessment of substance use and suicide risk. Several institutions have developed standardised templates in electronic health record systems to ensure consistent practice and traceability.

Municipalities without healthcare services available at night, on weekends or on public holidays have established emergency on-call arrangements to ensure that all newly admitted prisoners receive a health assessment within 24 hours, in line with international human rights standards.

### ***Clearer follow-up of isolated prisoners***

The Parliamentary Ombud's findings have led to increased awareness of the risks associated with solitary confinement and the importance of daily medical supervision. Several healthcare services have introduced written routines for supervision and documentation, and specific forms have been developed within electronic record systems to register medical follow-up of isolated prisoners placed in security cells.

In order to better identify prisoners with mental health needs, several prisons have strengthened dialogue between healthcare personnel and the correctional services.

### ***Prevention and competence-building***

Several municipalities and health authorities have strengthened their competence in suicide

prevention. Staff have participated in VIVAT training programs, and suicide prevention has been incorporated into training for new employees.

Healthcare services also report more systematic cooperation with child and adolescent mental health services in the follow-up of minors and young prisoners, including joint meetings between healthcare providers, schools and youth teams.

### ***Medication management***

Following the Parliamentary Ombud's recommendations, several healthcare services have reviewed their medication management practices. Routines have been revised in order to safeguard patient privacy, reduce the risk of errors and ensure that healthcare personnel maintain professional independence.

In some prisons, new arrangements are being planned whereby prisoners will assume greater responsibility for certain non-addictive medications. The objective is to increase prisoners' sense of autonomy, improve patient safety, reduce stigmatisation and free up healthcare resources for prisoners with more complex follow-up needs.

### ***Ongoing challenges***

Feedback from healthcare services indicates clear improvements in efforts to ensure that prisoners receive adequate healthcare. At the same time, many institutions report persistent challenges related to limited resources and restricted availability during nights and weekends. Several respondents also emphasise the need for clearer national guidelines defining the division of responsibilities between the state and municipalities.

## Overview of prison visits 2024–2025

Visit report no.	Prison	Visit completed	Report published	Status per 31.12.2025
80	Ringerike Prison	February 2024	October 2024	Follow-up dialogue ongoing
81	Trondheim Prison and Preventive Detention Facility, Nermarka Unit	March 2024	October 2024	Closed
82	Indre Østfold Prison, Eidsberg Unit	April 2024	October 2024	Closed
83	Ålesund Prison	September 2024	December 2024	Closed
84	Stavanger Prison	September 2024	October 2024	Closed
85	Romerike Prison, Ullersmo Unit	February 2025	June 2025	Follow-up dialogue ongoing
86	Oslo Prison	February 2025	June 2025	Follow-up dialogue ongoing
87	Åna Prison	March 2025	June 2025	Closed
88	Agder Prison, Mandal Unit	March 2025	September 2025	Follow-up dialogue ongoing
89	Telemark Prison, Skien Unit	April and May 2025	October 2025	Follow-up dialogue ongoing
90	Bjørgvin Prison, Juvenile unit	May 2025	October 2025	Follow-up dialogue ongoing



Exercise yard in Agder prison, Mandal unit. Photo: The Parliamentary Ombud

## Other visits in 2025

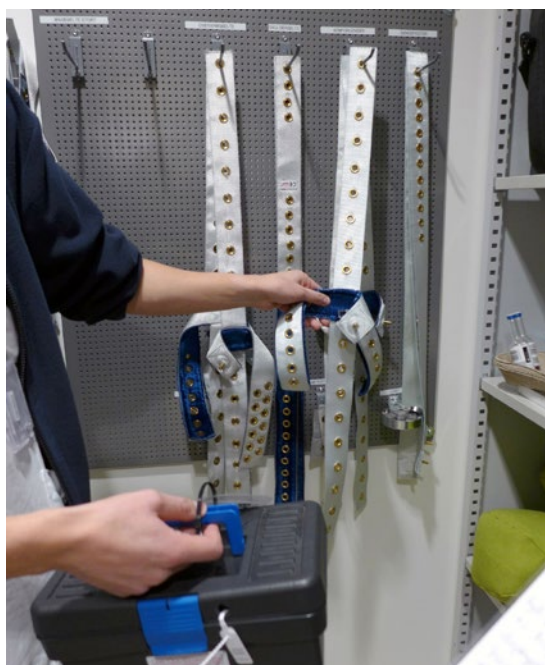
### Visits to mental health care institutions

In 2025, the Parliamentary Ombud initiated a thematic investigation into the use of mechanical restraints in mental health care. Mechanical restraints include devices that restrict patients' ability to move their arms and/or legs, such as transport belts or restraint beds. These measures are highly intrusive and entail a high risk of violations of patients' fundamental rights.

During the autumn of 2025, two visits to mental health care institutions were conducted. Reports from these visits are currently under preparation. The thematic investigation will continue in 2026.

### Visit to the Police Immigration Detention Centre at Trandum

At the end of November 2025, the NPM carried out a visit to the Police Immigration Detention Centre at Trandum. The centre is Norway's only institution for deprivation of liberty under the Immigration Act and is used to detain persons pending removal from the country. This places particularly strict requirements on how detention is carried out and on ensuring that the measures applied are proportionate to their purpose.



The Parliamentary Ombud examined the use of mechanical restraints in mental health care institutions. Photo: The Parliamentary Ombud

The Parliamentary Ombud has conducted a total of five visits to the immigration detention centre (2006, 2008, 2012, 2015 and 2017), of which the two most recent visits were carried out by the NPM.

### Overview of other visits in 2025

Visit report no.	Prison	Date of visit	Status per 31.12.2025
91	Sørlandet Hospital	October 2025	Report under preparation
92	Vestfold Hospital	November 2025	Report under preparation
93	Trandum Immigration Detention Centre	November 2025	Report under preparation

## Information and advisory work

In addition to visits, information and outreach activities constitute a central part of the NPM's mandate. The NPM is tasked both with disseminating its findings and recommendations to a broader audience and with promoting national-level changes where necessary in order to reduce the risk of inhuman or degrading treatment of persons deprived of their liberty.

In 2025, the NPM published a thematic report on the use of interpreters in prisons, a thematic report on

prisoners' contact with the outside world, and a thematic report on the use of security cells. We also submitted a special report to the Storting (the Norwegian Parliament) on lock-up practices and de facto isolation.

Based on findings from visits, the NPM held meetings with relevant national authorities, submitted consultation responses, delivered presentations and conducted training activities.

### Advisory council

The Advisory Council of the National Preventive Mechanism provides expertise, information, advice and input to the NPM's work. The Council consists of both individual members and representatives from selected organisations. Members are appointed for two-year terms.

The Advisory Council met three times in 2025. The meetings addressed a range of thematic areas, and the Council's input and advice during the planning of visits to mental health care institutions were particularly valuable to the NPM's work.

### Members of the Advisory Council in 2025

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

### **Special report to the Storting on confinement and de facto isolation**

Serious findings from visits to high-security prisons led the Parliamentary Ombud in 2025 to submit a special report to the Storting on confinement and de facto isolation.

Following this, the Government submitted a legislative proposal to the Storting, Proposition 165 L (2024–2025), with the aim of reducing the use of isolation in prisons.

The proposal follows up several of the Parliamentary Ombud's recommendations and will be considered by the Storting in spring 2026.

### **Thematic report on the use of interpreters in prisons**

In April 2025, the NPM published a thematic report on the use of interpreters in prisons. The report was based on findings from 29 visits to high-security prisons conducted during the period 2014–2024.

The report showed that interpreters are very rarely used upon admission to prison and during the early phase of imprisonment. At this stage, both prisoners and prisons have a particularly strong need to exchange information. The ability to understand what is being communicated also remains important throughout imprisonment in order to prevent misunderstandings, unnecessary use of coercion and frustration.

The Directorate of the Norwegian Correctional Service is responsible for following up the recommendations contained in the report.

### **Thematic report on contact with the outside world**

In April 2025, the NPM also published a thematic report on prisoners' opportunities to maintain contact with family and friends. The report was

based on findings from 29 visits to high-security prisons conducted during the period 2014–2024.

The findings show that prisoners in practice have limited opportunities to maintain contact with their closest relatives. Telephone access is restricted, rules governing video calls are unclear, and capacity constraints make it difficult to obtain extended call time or more frequent contact.

This weakens prisoners' right to respect for private and family life and may affect both mental health and reintegration into society. The Directorate of the Norwegian Correctional Service is responsible for following up the recommendations contained in the report.

### **Thematic report and seminar on the use of security cells in prisons**

At the beginning of December 2025, the NPM organised a breakfast seminar in connection with the launch of its thematic report on the use of security cells in prisons.



Panel discussion. Participants from left: Tonje Østvold Byhre, Specialist Psychologist from the Parliamentary Ombud; Marianne Solberg, President of FO; Espen Jambak, Governor of Telemark Prison, Skien Unit; Lise Sannerud, Director of the Directorate of the Norwegian Correctional Service; and moderator Aslak Bonde. Photo: The Parliamentary Ombud

The report was based on investigations and visits to 13 prisons during the period 2023–2025 and identified several highly concerning practices, including prolonged placements, insufficient ongoing assessments and harsh physical conditions.

A professional panel discussion was held in connection with the launch, featuring Lise Sannerud, Director of the Directorate of the Norwegian Correctional Service; Marianne Solberg, President of the Norwegian Union of Social Educators and Social Workers (FO); Espen Jambak, Governor of Telemark Prison, Skien Unit; and Tonje Østvold Byhre, Specialist Psychologist at the Parliamentary Ombud.

Espen Jambak presented the measures implemented at Telemark Prison to reduce the use of security cells. In total, more than 150 participants attended the seminar in person or followed the event digitally.

### Consultation responses

As part of its preventive mandate, the Parliamentary Ombud submits consultation responses on matters affecting the rule of law and the human rights of persons who are, or may be, deprived of their liberty. Consultation work is used to convey experiences and findings from visits and investigations in order to ensure that legislation and guidelines better reflect Norway's international human rights obligations.

In 2025, the Parliamentary Ombud submitted two consultation responses and contributed to Department 2's response to NOU 2: Social Protection and Care.

### **Measures targeting children who commit repeated or serious criminal offences**

In September 2025, the Parliamentary Ombud submitted a consultation response to the Government's expert group responsible for the report *They Are Our Children – Keeping a Cool Head and a Warm Heart: Measures Targeting Children Who Commit Repeated or Serious Criminal Offences*. The report proposed several amendments to the Child Welfare Act, including expanded access to intrusive coercive measures in child welfare institutions and changes to the rules governing the duration of placements without consent.

The Parliamentary Ombud warned against implementing the proposals without a thorough human rights assessment. We emphasised that expanding the target group for the use of coercive measures could lead to significantly more children being subjected to highly intrusive interventions, and that weak compliance with existing regulations already entails a risk of inhuman treatment.

The Ombud also expressed concern regarding proposals to remove the current limitations on the duration of non-consensual institutional placements, as this could contribute to the normalisation of prolonged deprivation of liberty of children.





The NPM giving a lecture at the University College of Norwegian Correctional Service (KRUS).  
Photo: The Parliamentary Ombud

***The Parliamentary Ombud recommended that:***

- › The Government should not expand the target group for the use of coercive measures in child welfare institutions without first conducting a broad human rights assessment and evaluation of current practice.
- › Proposals to extend the duration of placements without consent should be carefully assessed in light of the UN Convention on the Rights of the Child and the European Convention on Human Rights.
- › Legal safeguards should be strengthened through clearer rules on necessity, proportionality and children's right to be heard.
- › The Government should develop a comprehensive legislative proposal regulating the use of coercion and force in child welfare institutions, as announced by the Ministry of Children and Families.

***Regulatory framework for deprivation of liberty at the Trandum Immigration Detention Centre***

In August 2025, the Parliamentary Ombud submitted a consultation response to the Ministry of Justice and Public Security regarding proposed amendments to section 107 of the Immigration Act and a new regulation governing the Police Immigration Detention Centre. The purpose of the consultation was to modernise and clarify the legal framework governing deprivation of liberty at Trandum.

The Parliamentary Ombud supported the need for clearer regulations but raised several concerns regarding the proposed changes. We pointed out that several of the new legal bases for the use of force, lock-up practices and coercive measures were more intrusive than those applicable in prisons, even though immigration detention does not constitute a criminal sanction.

Particular concern was expressed regarding the risk that the proposals could entrench a practice whereby the immigration detention centre becomes increasingly prison-like, in violation of international human rights standards requiring dignified treatment of persons deprived of their liberty.

***The Parliamentary Ombud recommended that:***

- ▶ A general legal basis for routine confiscation of mobile phones and electronic communication devices should not be introduced, and that such measures must be based on individual assessments.
- ▶ The legal basis for routine lock-up of prisoners should be limited and clarified.
- ▶ An absolute prohibition on the use of security cells for children should be introduced, in line with the UN Convention on the Rights of the Child and international standards.
- ▶ Collective exclusion from communal activities should not be permitted, as such measures are highly intrusive and unnecessary.
- ▶ Rules governing camera surveillance should be clearly limited to common areas and should not include prisoners' private rooms.
- ▶ All rules governing the use of force and restrictions should be clearly set out in legislation, rather than being divided between statutory provisions and regulations.
- ▶ Ongoing assessments of exclusion from communal activities and placements in security cells should be documented at least every six hours.

The Parliamentary Ombud emphasised that immigration detention constitutes an administrative deprivation of liberty, not a criminal sanction. Measures must therefore be designed accordingly and in compliance with international human rights standards and the prohibition against inhuman or degrading treatment.

**Dissemination of findings from the prison sector**

In 2024, the NPM published a thematic report documenting that minors were being placed together with adult prisoners at Indre Østfold Prison, Eidsberg Unit. The Parliamentary Ombud considers that the practice of placing children in prison alongside adults must cease.

The findings from the report were presented at the annual conference of KROM (the Norwegian Association for Penal Reform).

In addition, the NPM delivered presentations on high-security prisons at an internal seminar organised by the Eidsivating Court of Appeal. The NPM also introduced the preventive mandate and working methods to the newly established Supervisory Council for the Correctional Services and delivered presentations for the Centre for Research and Education in Mental Health Services (SIFER) on solitary confinement and healthcare services in prisons.

The NPM engaged in dialogue and knowledge exchange with organisations such as the Norwegian Red Cross, Gatejuristen (the Street Lawyers), Ung Rettshjelp (Youth Legal Aid) and the prison group of Jussbuss.

Lectures were delivered at the University College of Norwegian Correctional Service (KRUS), and inspections were carried out following invitations from the National Reinforced Communal Unit (NFFA) at Ila Prison and Preventive Detention Facility.



Meeting with the Nordic national preventive mechanisms in Reykjavik. Photo: The Parliamentary Ombud

### Dissemination of findings from other sectors

In 2025, the NPM continued to share knowledge from previous visits to child welfare institutions, mental health care institutions, nursing homes and residential facilities for persons with intellectual disabilities. Although no new reports were published in these sectors during the year, this work contributed to maintaining attention on conditions affecting particularly vulnerable groups in institutional settings.

During the year, the NPM delivered teaching sessions for social educator students at Østfold University College, psychology students at the University of Oslo, resident doctors at Østfold Hospital and Oslo University Hospital.

The NPM also delivered presentations at the Mathilde Day event organised by Forandringsfabrikken and at Lucy Smith's Children's Rights Day.

Such activities are important in strengthening knowledge on the prevention of torture and inhuman or degrading treatment across different institutional sectors.

### International cooperation

A total of 93 states has ratified the Optional Protocol to the UN Convention against Torture (OPCAT), and globally there are currently 78 national preventive mechanisms. International exchange of experience and dialogue contribute to mutual competence-building and further development of preventive work.

During the year, the NPM both initiated dialogue with other preventive mechanisms and responded to requests for cooperation. A digital meeting was held with the Australian Department of Justice focusing on organisational structure and staffing, strategic prioritisation of visits, methodological approaches and follow-up of feedback from national and international bodies.

The NPM also held a digital meeting with the Polish national preventive mechanism to exchange experiences regarding preventive work and the situation in Norwegian prisons.

The Parliamentary Ombud hosted a study visit from the Georgian national preventive mechanism, organised in cooperation with the Council of Europe. The visit provided an opportunity to exchange experiences regarding organisation, methodology and communication in preventive work. Common challenges related to healthcare follow-up and the use of security cells were discussed, as well as the conduct of institutional visits.



The Georgian and Norwegian NPM exchanged experiences and knowledge.  
Photo: The Parliamentary Ombud.

In August, the NPM participated in the annual cooperation meeting between the Nordic national preventive mechanisms, which in 2025 was hosted in Reykjavik. Topics included the use of chemical restraints in institutions, how NPMs can balance strict standards with practical recommendations, and follow-up of prisoners with mental health needs.

Methodological and ethical issues related to visits were also discussed, including the protection of anonymity, the obligation to avoid causing harm, and how to minimise disruption to institutions' daily operations.



## Budget and accounts for 2025

Category	Budget 2025	Accounts 2025
<b>Salaries</b>	<b>14 575 000</b>	<b>12 116 229</b>
<b>Operating expenses</b>	<b>4 560 000</b>	<b>4 512 279</b>
Production and printing of visit reports, annual report and information material	280 000	302 955
Purchase of external services	335 000	424 827
Travel (visits and meetings)	905 000	405 937
Other operating expenses	455 000	685 943
Share of the Parliamentary Ombud's joint expenses (incl. rent, electricity, IT services, security, cleaning etc.)	2 585 000	2 692 617
<b>Total NOK</b>	<b>19 135 000</b>	<b>16 619 508</b>

\* Difference between budget and accounts due to delays in recruitment and newly recruited staff not taking up their positions until 2026.



Hatch at floor level for delivering food to persons in security cells. Telemark prison, Skien unit.  
Photo: The Parliamentary Ombud.



Security cell in Trondheim prison and Preventive Detention Facility. Photo: The Parliamentary Ombud

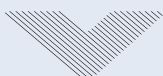


# How a NPM visit is carried out

**Prepare for the visit  
and gather information**



**Conduct the visit**



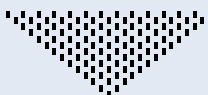
**Write a report**



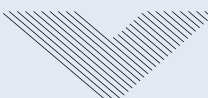
**Publish the report with findings  
and recommendations**



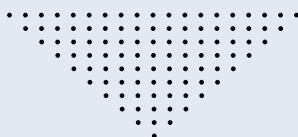
**The place of detention follows up the  
recommendations in the report**



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



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



**Closing the case**

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