SIVILOMBUDET
Norwegian Parliamentary Ombud

# HEALTHCARE SERVICES FOR PRISONERS 2026

**THE PARLIAMENTARY OMBUD'S PREVENTIVE UNIT** is mandated to prevent torture and other cruel, inhuman or degrading treatment or punishment of persons deprived of their liberty. As part of this work, we visit prisons to assess whether the correctional services and healthcare services comply with their human rights obligations.

Photo: The Parliamentary Ombudt

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

# Table of contents

# Summary

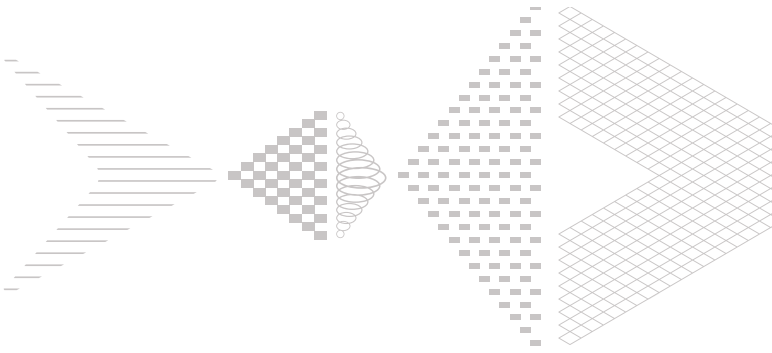
**This report sets out the Parliamentary Ombud's findings regarding healthcare services in fifteen prisons during the period 2023–2025. Our investigations reveal repeated and serious deficiencies in the healthcare provided to prisoners. These include failures to assess prisoners' healthcare needs, delays and interruptions in treatment, inadequate accessibility, and a lack of opportunities to communicate confidentially with healthcare services.**

One of the serious findings is that many prisons do not systematically assess and monitor suicide risk, and they lack adequate systems for implementing evidence-based suicide prevention measures. There is insufficient attention to, and little systematic work on, known vulnerabilities among prisoners.

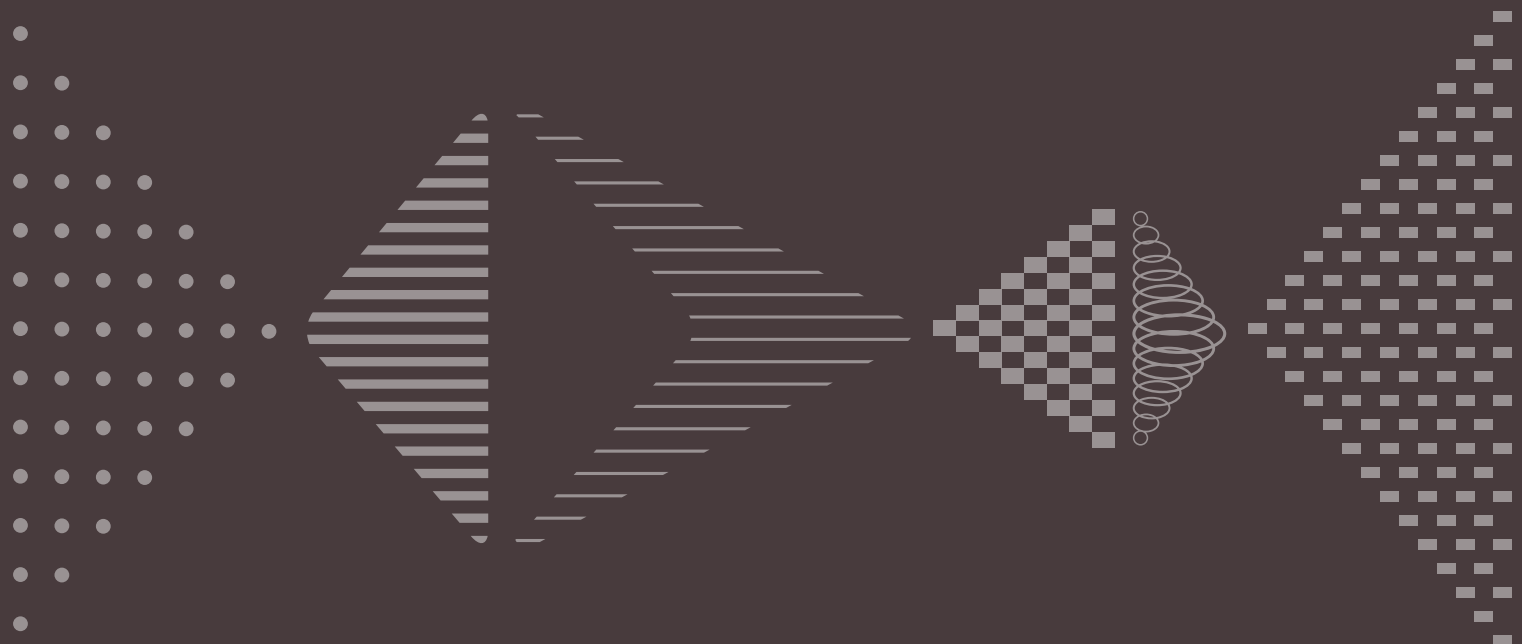
Prisoners held in isolation do not always receive daily supervision from healthcare personnel. This is a critical finding. Most recently, in 2025, the Parliamentary Ombud alerted the Storting in a special report[1] that the use of lock-up and de facto isolation in Norwegian prisons entails a risk of violating the prohibition in human rights law against inhuman or degrading treatment. In many cases, healthcare services are unaware of the extent of lock-up in prisons, which weakens their ability to follow up conditions that may contribute to isolation-related harm.

In nearly all the prisons, there were clear deficiencies in healthcare personnel's supervision of prisoners held in isolation. In several prisons healthcare services lacked knowledge about the health-related consequences of isolation. We are particularly concerned about the lack of supervision of prisoners placed in security cells. Placement in a security cell is the form of isolation most harmful to health. In addition, the use of force during placement in a security cell may result in injuries going undetected when prisoners are not supervised by healthcare personnel. Another serious finding was that healthcare services in several prisons did not provide daily medical supervision of prisoners who had been remanded in custody in isolation.

Combined, these findings imply that important information about prisoners' health is not identified. This creates a risk that prisoners do not receive the healthcare they are entitled and that their health deteriorates. The Parliamentary Ombud considers that these findings may constitute violations of prisoners' rights to life and health. Prisoners' healthcare needs differ from those of the general population. Higher levels of illness among prisoners, limited autonomy, and isolation place a particular responsibility on the state and impose highly specific requirements on prison healthcare services. The findings described in this report are linked to three overarching challenges: 1) insufficient knowledge about prisoners' health problems and prison conditions, and what these mean for healthcare services; 2) healthcare services are not staffed adequately to protect prisoners' healthcare rights; and 3) insufficient cooperation between the Correctional Service and the primary and specialist healthcare services.



1 Parliamentary Ombud (2025). Special Report to the Storting on lock-up and de facto isolation in prisons. Document 4:1 (2024/25).



# Recommendations

Based on our findings, the Parliamentary Ombud recommends:

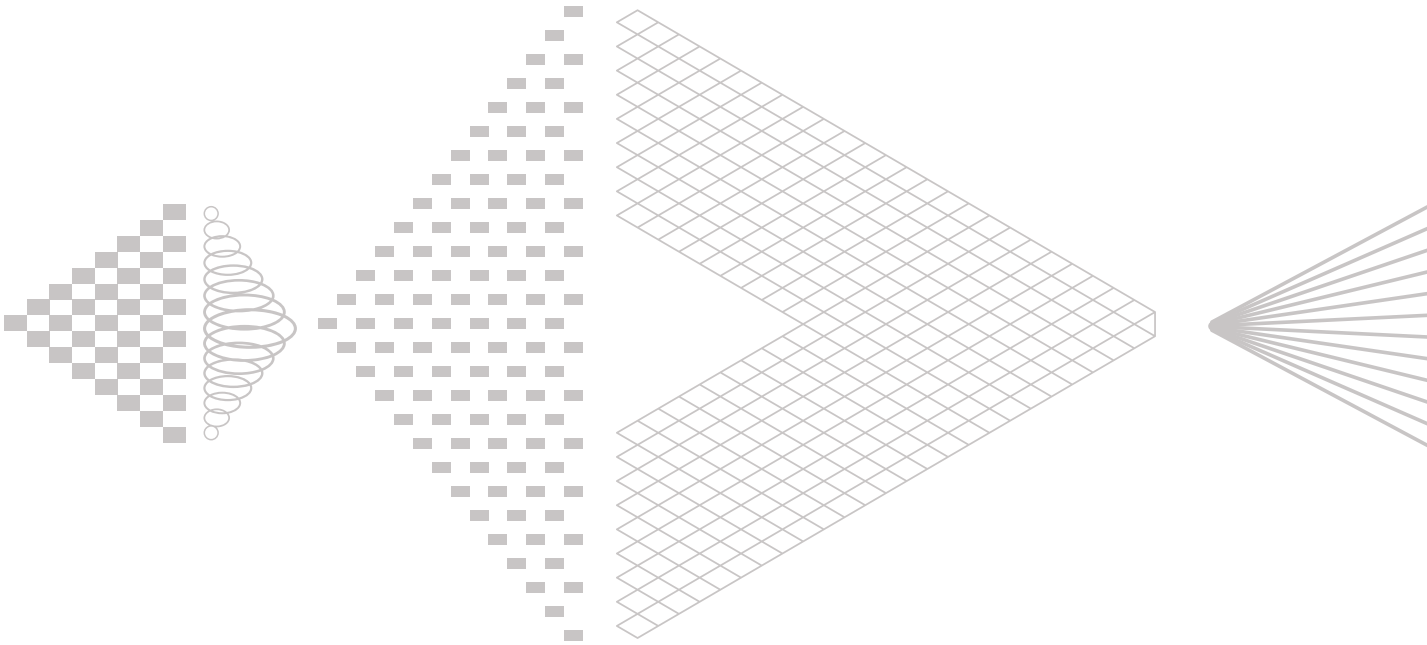
1) that the health authorities ensure that prison healthcare services comply with international standards for prison healthcare and meet the particular healthcare needs of prisoners.

2) that the health authorities implement measures to ensure that healthcare personnel providing healthcare to prisoners possess a high level of competence in delivering healthcare to persons deprived of their liberty. This also includes the duty to notify prison management and supervisory authorities of circumstances relevant to patient safety.

3) that the health authorities and the Correctional Service implement measures to ensure effective cooperation between municipal health and care services, specialist healthcare services and the Correctional Service.

4) that the health authorities ensure that all prisoners held in isolation receive daily supervision from healthcare personnel, including at weekends and on public holidays.

5) that the health authorities ensure that harm resulting from isolation, prolonged confinement and self-isolation is properly followed up.



# 1. Introduction

Norwegian authorities have a human rights obligation to safeguard prisoners' life and health during imprisonment.[2] This also includes preventing, investigating and treating health-related harm resulting from prison conditions. Where prisoners do not receive adequate medical supervision or healthcare, this may constitute a breach of the prohibition against inhuman or degrading treatment. In the most serious cases, failures in healthcare may violate the right to life.[3]

In Norwegian prisons, healthcare services for prisoners are organised according to the so-called "import model". This means that responsibility for healthcare and care services in prisons lies with the health authorities.[4] The purpose is to ensure that prisoners have access to healthcare and care services on an equal basis with others, and to ensure that healthcare personnel in prisons have a free and independent role vis-à-vis the Correctional Service.[5] This organisation of healthcare services for prisoners is in line with international minimum standards.[6] The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) specify that the relationship between prisoners and healthcare personnel shall be governed by the same ethical and professional standards as apply outside prison.[7]



2 ECtHR Kudła v. Poland, application no. 30210/96, 26 October 2000, paras. 92–94; Idalov v. Russia, application no. 5826/03, 22 May 2012, para. 93; Muršić v. Croatia, application no. 7334/13, 20 October 2016, para. 99; Haugen v. Norway, application no. 59476/21, 15 October 2024. See also the International Covenant on Economic, Social and Cultural Rights, Article 12; United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) (2015), annex to GA Res 70/175, Rule 24; and the European Prison Rules (2020), Rec(2006)2-rev, Rule 39.

3 European Convention on Human Rights (ECHR), Article 2. See ECtHR Haugen v. Norway, application no. 59476/21, 15 October 2024.

4 Municipalities with prisons have a statutory responsibility for healthcare and care services for prisoners pursuant to the Act of 24 June 2011 No. 74 relating to Municipal Health and Care Services (the Health and Care Services Act), section 3-9. County authorities are responsible for the provision of dental services, and Regional health authorities are responsible for specialist healthcare services for prisoners pursuant respectively to the Act of 3 June 1983 No. 73 relating to Dental Services (the Dental Services Act), section 1-3, and the Act of 2 July 1999 No. 74 relating to Specialist Healthcare Services etc. (the Specialist Healthcare Services Act), section 2-1a.

5 Norwegian Directorate of Health (2013). Guidelines for Healthcare and Care Services for Prisoners, p. 12; Norwegian Directorate of Health (2025). Healthcare and Care Services for Prisoners: Guidelines to Legislation and Regulations. First published 22 September 2025.

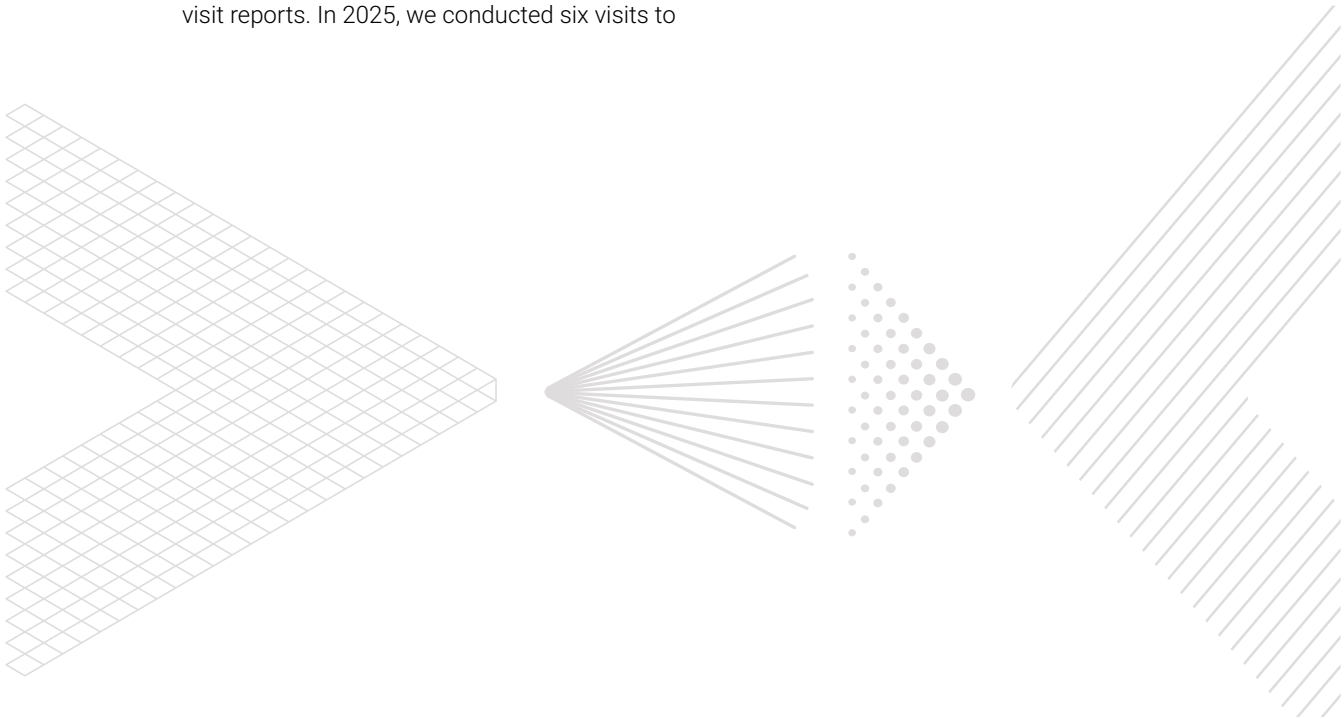
6 See for example WHO (2014). Prisons and Health, p. 7; United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) (2015), annex to GA Res 70/175, Rule 24(2); Council of Europe, European Committee for the Prevention of Torture and Inhuman og Degrading Treatment or Punishment (CPT), Extract from the 3rd General Report, Healthcare Services in Prisons, 1993, CPT/Inf (1993) 12, para. 71.

7 Mandela Rules (2015), Rule 32.

# 2. About the report

Since 2014, the Parliamentary Ombud has conducted visits to 36 prisons. These visits have primarily examined matters falling within the responsibility of the individual prison and the Correctional Service. At the same time, healthcare services for prisoners have also been an important part of the investigations. Following all prison visits, we have issued recommendations to the healthcare services, which have subsequently been followed up through dialogue between the healthcare services and the Parliamentary Ombud. During the period 2023–2024, we placed additional emphasis on cooperation between healthcare services and prisons during our visits. During this period, we published nine visit reports. In 2025, we conducted six visits to high-security prisons where the theme of the visit was limited to the use of security cells. As the role of healthcare services when prisons use security cells is relevant, this report also includes findings from these visits.[8]

Through these visits, the Parliamentary Ombud has uncovered repeated and serious deficiencies in the healthcare provided to prisoners. In this report, we take a closer look at the overall findings from the period 2023–2025 and examine why these conditions make it difficult to follow up prisoners' healthcare needs in an adequate manner.



8 Visits to Bredtveit and Ullersmo Prisons, Zulu East Unit; Halden Prison; Froland Prison; Bodø Prison; Ringerike Prison; Trondheim Prison and Preventive Detention Facility, Nermarka Unit; Eidsberg Prison; Ålesund Prison; and Stavanger Prison. Visits limited to the use of security cells: Oslo Prison; Ullersmo Prison; Åna Prison; Mandal Prison; Skien Prison; and the Youth Unit West. We have not investigated prisoners  access to dental services.

# 3. Prisoners' right to healthcare services and the prohibition against inhuman treatment

Prisoners are entitled to the same healthcare services as the rest of the population.[9] This is set out in the Mandela Rules and the European Prison Rules.[10] In the work to ensure equivalent healthcare services, three factors are particularly important:

## 1. Prisoners are in poorer health than the general population

It is well documented that morbidity among prisoners is higher than in the general population. Several studies show that a significant proportion of prisoners suffer from chronic illnesses, multiple concurrent diagnoses, substance abuse problems, mental disorders and an accumulation of social disadvantages.[11] Estimates of the number of prisoners in Norwegian prisons who meet the criteria for a mental disorder requiring treatment, vary between 20 and nearly 50 per cent.[12] There is also an overrepresentation of prisoners with intellectual disabilities compared with the general population, and probably more prisoners who meet the diagnostic criteria without having received a diagnosis.[13]

The number of elderly prisoners is steadily increasing. The proportion of prisoners over the age of 50 rose from 6 per cent in 2000 to 19 per cent in 2019.[14] This also has implications for prisoners' healthcare needs, as older people have a greater need for healthcare and care services.

A greater proportion of prisoners than people in the general population carry trauma resulting from violence or sexual abuse. The proportion of female prisoners who have experienced sexual abuse is particularly high.[15] Many prisoners have had difficult childhoods marked by poverty, abuse or substance misuse. Prisoners also have lower levels of education and lower rates of employment than the general population.[16] These factors are themselves associated with poorer health.

The risk of suicide is high among prisoners, partly because of poor mental health and substance misuse.[17] In addition, prison conditions such as lack of social contact and the experience of losing control over one's own life contribute to an increased risk of suicide.[18]

9 The right to healthcare is established in section 3-1, first and second paragraphs, of the Health and Care Services Act.

10 Mandela Rules (2015), Rule 24.1; European Prison Rules, Rules 40.3 and 40.5.

11 See, for example, Tverborgvik, T., Stavseth, M.R. et al. (2024). *Living Conditions, Substance Use and Mental Health among Persons Who Have Been Imprisoned or Have Served Sentences in the Community.* SERAF Report 5/2024; Cramer, V. (2014). Prevalence of Mental Disorders among Convicted Persons in Norwegian Prisons, Oslo University Hospital.

12 Cramer, V. (2014). Prevalence of Mental Disorders among Convicted Persons in Norwegian Prisons, Oslo University Hospital, p. 11.

13 See, for example, Søndenaa, E., Rasmussen, K., Palmstierna, T. and Nøttestad, J. (2008). The prevalence and nature of intellectual disability in Norwegian prisons, *Journal of Intellectual Disability Research, 52* (12), pp. 1129–1137.

14 Norwegian Correctional Service Directorate (2020). Older Prisoners in Norwegian Prisons: Situation, Analysis, Challenges and Solutions, p. 12.

15 Amundsen, Marie-Lisbet (2010). "Behind the Veil of Oblivion", FONTENE Research 1/10, pp. 4–15.

16 Revold, M.K. (2014). Prisoners' Living Conditions 2014. Statistics Norway Reports 2015/47.

17 Bukten, A. and Stavseth, M.R. (2021). "Suicide in prison and after release: a 17-year national cohort study", European Journal of Epidemiology, 36, pp. 1075–1083; Cramer, V. (2014). Prevalence of Mental Disorders among Convicted Persons in Norwegian Prisons, Oslo University Hospital, p. 11.

18 WHO (2007). Preventing Suicide in Jails and Prisons.

## 2. Deprivation of liberty limits prisoners' ability to maintain their own health

Prisoners are under the control of the authorities and are deprived of the opportunity to seek healthcare services independently in the community. The severe restrictions on personal autonomy, physical conditions, and the limited opportunities for activities such as exercise, make it more difficult for prisoners to take care of their own health. This includes, for example, maintaining a healthy diet, engaging in health-promoting activities, getting sufficient sleep, and receiving support from family members or others.

Prisoners are also subject to rules granting the authorities the right to use coercion and physical force. The use of coercion and force carries a risk of both physical and psychological harm.

## 3. Extensive use of isolation in prisons

The Parliamentary Ombud is concerned about the use of isolation and the lack of human contact in Norwegian prisons. Isolation and the lack of human contact are intrusive and harmful to health.

In 2019, we published a special report to the Storting containing several recommendations, including the establishment of a common professional framework for prison healthcare services; statutory regulation of healthcare services' responsibility for following up prisoners held in isolation; and a revision of the national guidelines for healthcare and care services for prisoners.[19] Our recommendations have been partly addressed by the authorities. In spring 2019, the Norwegian Directorate of Health established an advisory council for healthcare, care and dental services for prisoners. In August 2025, the Government proposed amendments to the Execution of Sentences Act and the Health and Care Services Act. The proposal would introduce a statutory requirement for daily healthcare supervision of prisoners held in security cells or restrained in security beds, but not a corresponding requirement for prisoners isolated by other means.[20] The Norwegian Directorate of Health updated its guidelines for healthcare and care services for prisoners in September 2025.[21]

A negative development, involving increased lock-up and isolation in the years following 2019, led the Ombud in 2025 once again to alert the Storting through a new special report concerning our concerns about the extent of isolation in Norwegian prisons.[22] This development, combined with increasing morbidity among prisoners, causes the Ombud concern that healthcare services are not sufficiently equipped to meet the needs of this patient group.

### *Special circumstances place special demands on prison healthcare services*

The combination of high levels of illness, limited autonomy and freedom of movement, isolation, and legal powers permitting the use of force places a particular responsibility on the state to ensure healthcare for prisoners. Equivalent services mean that the services provided must meet needs that are both quantitatively and qualitatively different from those in the wider community. Providing healthcare services to prisoners therefore raises distinct challenges and places particular demands on prison healthcare services.

19 Parliamentary Ombud (2019). Special Report to the Storting on Isolation and Lack of Human Contact in Norwegian Prisons. Document 4:3 (2018/2019).

20 Proposition 165 L (2024–2025) Amendments to the Execution of Sentences Act etc. (Isolation in Prison).

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

22 Parliamentary Ombud (2025). Special Report to the Storting on Lock-up and De Facto Isolation in Prisons. Document 4:1 (2024/25).

# 4. Key findings from visits conducted in 2023–2025

## 4.1 Assessment of prisoners' healthcare needs

Healthcare assessments are important in identifying prisoners' healthcare needs and documenting injuries that may have occurred during arrest and transport. Such assessments also provide a basis for determining whether prisoners develop symptoms of harm resulting from prison conditions. If healthcare needs are not assessed upon admission, prisoners risk missing out on necessary treatment. It also becomes more difficult for healthcare personnel to monitor whether prisoners are suffering harm as a result of imprisonment. This is particularly important when prisoners are subjected to isolation.

Both the European Prison Rules and the Mandela Rules recommend that healthcare personnel examine prisoners as soon as possible after arrival at prison.[23] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) emphasises that such healthcare assessments should take place within the first 24 hours following admission.[24] The Norwegian Directorate of Health's new guidelines recommend that prison healthcare services should offer all prisoners an admission interview within 24 hours.[25]

### ▶ Finding 1: Delayed or absent healthcare assessments

Healthcare assessments were often not carried out in accordance with human rights standards requiring them to take place shortly after admission and no later than within 24 hours:

- Almost none of the healthcare services ensured, as a general rule, that prisoners received an admission interview within 24 hours.[26]
- In three prisons, only around half of the prisoners had been interviewed within 24 hours of admission.
- The absence of dates in the documentation often made it impossible to establish whether the admission interview had taken place within 24 hours.

One reason why admission interviews were delayed was that admissions took place on Friday afternoons or later during the weekend. Only a small number of healthcare units are open during this period, meaning that the admission interview must then be carried out by staff from out-of-hours emergency medical services. Failure by the prison to notify the services, capacity challenges, or lack of familiarity with the Directorate of Health's guidelines meant that the emergency medical services did not carry out the assessment.

### ▶ Finding 2: Healthcare assessments do not provide sufficient information to follow up prisoners' health

Admission assessments should include, among other things, physical and mental health conditions, previously diagnosed illnesses and ongoing treatment, signs of disproportionate use of force, withdrawal symptoms related to substance misuse, stress associated with deprivation of liberty, infectious diseases, and any physical or mental health conditions requiring care after

23 European Prison Rules (2020), Rec(2006)2-rev, Rules 15 and 42.1; Mandela Rules (2015), Rule 30(1).

24 CPT (2025). Healthcare in Prison: Prison Standard, CPT/Inf (2025) 37, para. 10. See also CPT (2019). Report to the Norwegian Government on the Visit to Norway, CPT/Inf (2019) 1, para. 93.

25 Norwegian Directorate of Health (2025). Healthcare and Care Services for Prisoners: Guidelines to Legislation and Regulations. First published 22 September 2025. The previous guidelines recommended that an admission interview be conducted shortly after admission, that medication use be assessed immediately, and that a more detailed examination and interview with the prisoner should take place within 24 hours, see Norwegian Directorate of Health (2013/2016). Healthcare and Care Services for Prisoners: Guidelines, IS-1971, p. 19

26 We found the same in one additional prison, but due to missing dates in part of the material, it was not possible to determine whether this applied to all the cases we examined.

release, including arrangements for continuity of care.[27] The Norwegian Directorate of Health's new guidelines contain a detailed description of what an admission assessment should include.[28]

Overall, admission assessments were too superficial. Several assessments were brief or limited to keywords and provided a weak basis for further follow-up. In some places, admission records were incomplete, even where templates and forms for admission interviews existed. Where templates were used, the information often consisted only of "yes" or "no" answers to various questions, without further information about the prisoner's health condition.

In many prisons, healthcare personnel had weak or non-existent procedures for assessing and documenting injuries that prisoners had upon admission. This issue has repeatedly been raised by the CPT during visits to Norway. Nevertheless, we found that healthcare personnel still have insufficient knowledge of the risk of injuries in connection with arrest and admission to police custody and prison (see Finding 13: Healthcare personnel must not approve the prison's use of force).[29]

Poor assessment of prisoners' health makes it difficult to identify healthcare needs and provide necessary treatment. This may lead to deterioration in prisoners' health and, in the most serious cases, loss of life.

### ▶ Finding 3: Assessment of suicide risk is not carried out systematically

Prisoners are at increased risk of suicide, and both the prison and the healthcare services have an independent responsibility to identify suicide risk and implement preventive measures.[30] [31]

In several cases, the European Court of Human Rights (ECtHR) has established that, in order to safeguard the right to life, the state is required to provide adequate medical care and monitoring for prisoners at risk of suicide as a suicide prevention measure.[32] In 2024, Norway was found by the ECtHR to have violated Article 2 of the European Convention on Human Rights (ECHR), the right to life, after a prisoner took his own life.[33] The ECtHR found that the prisoner had received only limited medical supervision and treatment despite his extensive mental health problems. There were shortcomings in coordination and communication between the prison and the various health authorities involved, both inside and outside the prison.

In 2025, the state reached a settlement with the bereaved relatives in another case following the suicide of a prisoner in custody. The settlement requires the state to implement measures to strengthen prison conditions for vulnerable prisoners in need of mental healthcare.[34]

In more than half of the prisons we investigated, healthcare units did not carry out suicide risk assessments systematically. Not all the healthcare units we visited had their own procedures for assessing and evaluating suicide risk.

Substance misuse is a risk factor for suicide.[35] This is one of several reasons why it is important to assess prisoners' substance use. Where substance use assessments were carried out, they were often lacking in detail and no scoring tools were used.[36] In more than half of the prisons we visited, information about prisoners' substance use was missing. This causes us concern that substance use, substance dependence

27 European Prison Rules, Rule 42.3.

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

29 See CPT (2025). Report to the Norwegian Government on the Visit to Norway, CPT/Inf (2025) 3, paras. 53 and CPT (2019). Report to the Norwegian Government on the Visit to Norway, CPT/Inf (2019), paras. 91–95.

30 Norwegian Directorate of Health (2017/21). National Professional Guidance: Self-Harm and Suicide – Guidance Material for Municipal Prevention Work; Norwegian Directorate of Health (2025). Healthcare and Care Services for Prisoners: Guidelines to Legislation and Regulations. First published 22 September 2025.

31 Mandela Rules (2015), Rule 30; European Prison Rules, Rule 47.

32 ECtHR Keller v. Russia, application no. 26824/04, 17 October 2013, para. 82; ECtHR Keenan v. the United Kingdom, application no. 27229/95, 3 April 2001.

33 ECtHR Haugen v. Norway, application no. 59476/21, 15 October 2024.

34 Elden Law Firm (2025). "Settlement in the Jonatan Case: The State Reaches Settlement with the Bereaved". Published 20 February 2025. elden.no

35 Myklestad, I., Stene-Larsen, K. et al. (2023). A Review of Published Research and Knowledge Gaps in the Field of Suicide in Norway. Report 2023. Oslo, Norwegian Institute of Public Health, p. 45.

36 A scoring tool is a standardised assessment or evaluation instrument used to measure, assess or monitor a person's health condition. These tools provide healthcare personnel with an objective basis for assessing severity, treatment needs and changes over time.

and withdrawal conditions are not being identified. This increases not only the risk of suicide, but also the risk of health-related harm and fatal overdoses.

### ▶ Finding 4: Healthcare units do not make sufficient use use of interpreters in consultations with prisoners

Healthcare services are required to use qualified interpreters when patients do not have sufficient command of Norwegian to understand the information provided or to participate in decisions regarding healthcare.[37] Foreign nationals account for between 25 and 30 per cent of prisoners in Norwegian prisons. Some of them speak little or no Norwegian. In order for them to receive and provide important information, they are therefore dependent on communicating in a language they understand.[38]

Several visits revealed insufficient use of qualified interpreters during healthcare consultations. In some cases, digital translation tools were used, while in other cases prison officers or fellow prisoners assisted in communication with healthcare personnel. Digital translation using tablets or assistance from prison staff and prisoners with language skills must not replace qualified interpreters in conversations concerning confidential information, such as prisoners' health.

## 4.2 Monitoring prisoners' health during imprisonment

Our visits have revealed several factors contributing to prisoners' healthcare needs not being followed up adequately. Failure to provide healthcare may have serious consequences for prisoners and, in the worst cases, lead to serious illness and death.

### ▶ Finding 5: It is difficult for prisoners to communicate confidentially with healthcare services

In order for prisoners to receive healthcare, they must be able to contact healthcare services. They must be able to do so confidentially and without prison staff reviewing their requests.[39]

In all the prisons, it was a problem that prisoners could not contact the healthcare unit without the risk of information being disclosed. In most of the prisons we visited, prisoners were required to submit written request slips when they wished to contact the healthcare unit. In several prisons, envelopes were not used when prisoners submitted request slips, and prisoners had to ask for envelopes. These were often left unsealed. We saw examples of prisoners who did not speak Norwegian or English, or who had disabilities that made writing difficult, having to receive assistance from prison officers in writing their requests. This means that prison officers gain access to healthcare information they should not have.

Two of the prisons had introduced digital systems enabling prisoners to book appointments with the healthcare unit themselves. However, the system was only available on stationary screens mounted on the walls in communal areas. This meant that others could see what prisoners were writing.

When prisoners are not able to contact healthcare personnel confidentially, they risk not receiving healthcare for problems they do not wish to share with others. This may worsen prisoners' health conditions and result in healthcare services missing important information about prison conditions that may affect prisoners' health.

Many prisoners expressed frustration that it could take a long time to receive a response to their request slips, or that the slips were not always answered. In several


Photo: The Parliamentary Ombud

37 This follows, inter alia, from the Act of 2 July 1991 No. 63 relating to Patients' and Users' Rights (the Patients' and Users' Rights Act), sections 3-2 and 3-5, and the Act of 11 June 2021 No. 79 relating to Public Authorities' Responsibility for the Use of Interpreters etc. (the Interpreters Act).

38 Parliamentary Ombud (2025). Use of Interpreters in Norwegian Prisons, p. 5.

39 CPT (2025). Healthcare in Prison: Prison Standard, CPT/Inf (2025) 37, para. 26.

prisons, the healthcare units had no system for documenting when they received a request slip from a prisoner or when they responded to a request. It was therefore difficult to know whether request slips had been received and difficult for healthcare services to monitor how long it took from receipt of a request until the prisoner received a response. This creates a risk that healthcare services overlook requests and increases the danger that prisoners do not receive necessary healthcare.

In prisons where digital communication systems had been introduced, prisoners had to understand Norwegian or English in order to use the system. In addition, the systems could be difficult to use for people with certain disabilities.

Healthcare services often lacked knowledge about the difficulties prisoners faced in contacting them.

### ▶ Finding 6: Inadequate care of prisoners with extensive healthcare needs or suicide risk

The visits identified two particular shortcomings in the care of prisoners with serious healthcare needs that may amount to violations of the prohibition against inhuman treatment and, in the most serious cases, the right to life.[40]

***Prisoners with extensive healthcare and care needs***

In some prisons, prisoners with major and serious needs had not been followed up adequately. This concerned both physical and mental health conditions. We saw an example of a prisoner requiring round-the-clock care who did not receive assistance outside the healthcare unit's opening hours. The prisoner required help with mobility, eating, drinking, changing incontinence pads, dressing, showering and using the toilet, and had been left lying in his own faeces for several hours. One of the reasons for this was that, in practice, it was not possible to obtain assistance and care from municipal home nursing services during the night.

In another prison, we found that a prisoner with particularly extensive care needs due to progressive physical illness, pain and severe mental health problems required assistance with mobility, showering and using the toilet. Despite this, no agreement had been entered into with municipal services for home nursing care.

> "During the visit, information emerged from several different sources indicating that one of the prisoners present at the time of the visit should not have been in prison. Staff from the healthcare unit, specialist healthcare services and the prison all considered that the prisoner should have been admitted to hospital or another suitable institution in order to receive appropriate care. It is concerning that a prisoner with serious health problems, whom both the prison and the healthcare services agreed should not be in prison, nevertheless remained in prison for several years. The Parliamentary Ombud is not aware of any initiative having been taken by the prison, the healthcare unit or the specialist healthcare services on the grounds that it was not justifiable to care for the prisoner in prison."
>
> Extract from the Parliamentary Ombud (2024), Report from the visit to Trondheim Prison and Preventive Detention Facility, Nermarka Unit, p. 55

***Prisoners at risk of suicide and with mental ill health***

Both events in a prisoner's life and prison conditions may increase the risk of suicide. Healthcare personnel must therefore monitor prisoners' overall health situation. This depends on good ongoing communication with the prison (see Finding 16: Deficiencies in cooperation between primary healthcare services, specialist healthcare services and the Correctional Service). We found several examples of prisoners at risk of suicide or with extensive healthcare and care needs where the healthcare unit considered that it was not justifiable for the prisoner to remain in prison, without this leading to concrete measures being taken by the healthcare services (see Finding 12: When healthcare personnel fail to report concerns).

In its most recent report on Norway, the CPT considered the services available to prisoners with mental ill health to be inadequate.[41] The Committee also made what is termed an "immediate observation" concerning three prisoners who were seriously ill and whom the Committee required to be transferred to psychiatric care.[42]

40 See ECtHR Haugen v. Norway, application no. 59476/21, 15 October 2024.

41 CPT (2025). Report to the Norwegian Government on the Visit to Norway, CPT/Inf (2025) 3.

42 CPT (2025). Report to the Norwegian Government on the Visit to Norway, CPT/Inf (2025) 3, para. 121. Under Article 8(2), paragraph 5, of the European Convention for the Prevention of Torture, the Committee may communicate observations requiring immediate action directly to the relevant authorities during a visit.

### ▶ Finding 7: Cancelled escorts lead to interruptions in treatment

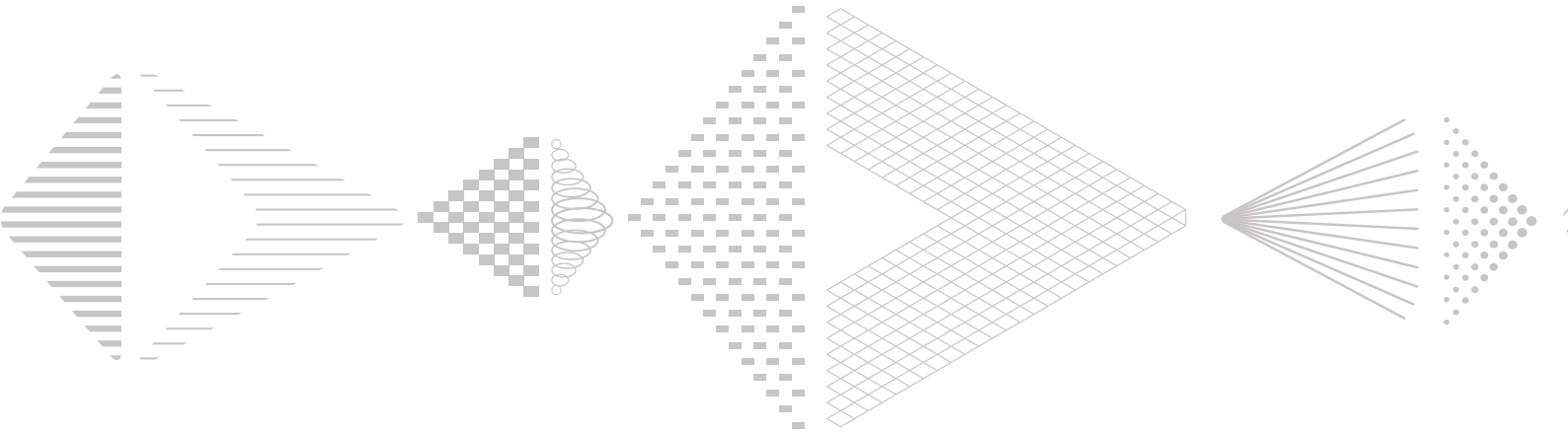
If a prisoner has a healthcare appointment outside the prison healthcare unit, for example an examination at a hospital, prison staff must escort the prisoner to the appointment ("escort"). For remand prisoners, the police are responsible for the escort. In several prisons, staff in the healthcare units were concerned that escorts to healthcare services outside the prison were being cancelled and pointed out that this was often due to understaffing within the police and the Correctional Service. Healthcare units did not always have an overview of cancelled escorts and did not always follow them up.

Cancelled escorts may result in prisoners missing necessary examinations and treatment. In addition, it can cause considerable frustration when a healthcare appointment that a prisoner has waited a long time for is cancelled at short notice. It may be important for prisoners to have the opportunity to prepare for a medical appointment, and information about appointments with specialist healthcare services should therefore not routinely be withheld from prisoners. Prisoners also lose the opportunity to complain about breaches of treatment time limits.[43] It is a shared responsibility of the prison, the police and the healthcare unit to ensure follow-up of cancelled healthcare escorts.

### ▶ Finding 8: Release and prison transfers between prisons may disrupt continuity of care

The Mandela Rules emphasise that continuity of treatment between healthcare services inside and outside prison must be ensured.[44] In several prisons, there was no system for obtaining prisoners' consent to transfer important healthcare information upon release or transfer between prisons. We saw examples where transfers between prisons created a significant risk of interruptions in care. We found healthcare units that refrained from sending referrals or initiating examinations because prisoners were soon to be transferred to another prison or released. This may result in prisoners missing important follow-up from specialist healthcare services or such follow-up being delayed. We also found that many prisons lacked procedures for informing healthcare services about planned transfers and releases. As a result, healthcare services did not transfer healthcare information to the healthcare services responsible for following up the prisoner in the new prison.

Continuity in healthcare is important, both for health-related reasons and because prisoners often have limited trust in healthcare personnel or may experience difficulties in seeking healthcare services following release. Admission to prison, transfers between prisons and release are all high-risk situations that may lead to interruptions in necessary treatment and increase the risk of suicide. Admission to prison and release may also increase the risk of severe withdrawal reactions or overdoses.[45]



43 Patients' and Users' Rights Act, section 7-2 cf. section 2-2a.

44 Mandela Rules (2015), Rule 24(2).

45 Groenewegen, P., Dirkzwager, A. et al. (2022). "The health of detainees and the role of primary care: Position paper of the European Forum for Primary Care", p. 4.

## 4.3 Healthcare for prisoners held in isolation

It is well established that isolation is harmful to health and that many prisoners in Norwegian prisons are subjected to extensive isolation.[46] The risk of health-related harm is the reason why, in a number of judgments, the ECtHR has established that where prisoners held in isolation do not receive regular supervision and medical care from healthcare personnel, this may constitute a violation of the prohibition against torture and inhuman treatment.[47] Healthcare personnel must therefore regularly monitor the physical and mental health of prisoners held in isolation.[48] According to the Mandela Rules, the isolation of prisoners with mental disorders, and isolation that contributes to worsening illness, is prohibited.[49]

The European Prison Rules, the Mandela Rules and the CPT standards for prison healthcare services all emphasise that healthcare personnel should examine prisoners upon placement in isolation and thereafter daily, and provide prompt medical assistance and treatment.[50] The rules further state that healthcare personnel must notify prison management if prisoners' physical or mental health deteriorates as a result of isolation, and advise on ending or reducing isolation on health-related grounds.[51]

The Ministry of Health and Care Services has also established that healthcare personnel are under a duty to follow up prisoners held in isolation on a daily basis.[52]

**Health-related harm caused by isolation**
Isolation is highly intrusive and harmful to health. This is thoroughly documented in the research literature. A large proportion of those subjected to isolation experience physical or psychological symptoms as a result of the isolation. The harmful effects depend, among other things, on the extent, severity and duration of the isolation and on factors relating to the prisoner.

The most common symptoms are psychological, but physical symptoms and complaints have also been documented. These include heart palpitations, sweating, insomnia, joint and back pain, impaired vision, poor appetite and digestive problems, exhaustion or weakness, trembling and sensations of cold. Psychological symptoms may range from anxiety, apathy and social withdrawal, concentration difficulties, hypersensitivity to noise and racing thoughts, to severe depression, panic disorder and acute psychosis. Increased levels of aggression, anger, self-harm and suicide attempts have also been reported. Isolation may also aggravate pre-existing conditions and illnesses.

46 See, for example, Parliamentary Ombud (2019). Special Report to the Storting on Isolation and Lack of Human Contact in Norwegian Prisons, Document 4:3 (2018/2019); Parliamentary Ombud (2025). Special Report to the Storting on Lock-up and De Facto Isolation in Prisons, Document 4:1 (2024/25).

47 ECtHR Keenan v. the United Kingdom, 4 March 2001, paras. 109–116. See also Khider v. France, application no. 39364/05, 9 July 2009, paras. 119–122; Rohde v. Denmark, application no. 69332/01, 21 July 2005, para. 99; Rivière v. France, application no. 33834/03, 11 July 2006, para. 63; Renolde v. France, application no. 5608/05, 16 October 2008, para. 120.

48 ECtHR Babar Ahmad and Others v. the United Kingdom, application no. 24027/07, 10 April 2012, para. 212. See also the report of the UN Special Rapporteur to the UN General Assembly (2011), A/66/268, para. 100.

49 Mandela Rules (2015), Rule 45(2).

50 CPT (2025). Healthcare in Prison: Prison Standard, CPT/Inf (2025) 37, para. 139; European Prison Rules, Rules 43.2–43.3; Mandela Rules (2015), Rule 46(1).

51 CPT (2025). *Healthcare in Prison: Prison Standard*, CPT/Inf (2025) 37, para. 139; European Prison Rules, Rules 43.3, 45.1 and 45.2; Mandela Rules (2015), Rules 46.2 and 46.3.

52 See Proposition 165 L (2024–2025) Amendments to the Execution of Sentences Act etc. (Isolation in Prison); Norwegian Directorate of Health (2025). *Healthcare and Care Services for Prisoners: Guidelines to Legislation and Regulations*. First published 22 September 2025.

Example of a security cell at Trondheim Prison.
Photo: The Parliamentary Ombud

Prisoners experiencing harmful effects will not always recognise the symptoms themselves or be able to communicate their need for healthcare. Healthcare personnel must themselves safeguard the healthcare needs of isolated prisoners through their own observations and examinations. It is not sufficient to rely on prisoners contacting healthcare services through prison officers.

In addition to safeguarding prisoners' health, the proactive work of healthcare services also serves a preventive function. Their supervision and presence may help reduce the risk of prisoners being subjected to violations. This is particularly important in situations involving the use of significant physical force, as is often the case when prisoners are placed in security cells.

Security cell at Åna Prison.
Photo: The Parliamentary Ombud

**Different forms of isolation in Norwegian prisons:**

*Ordered isolation:* Prisoners may be held in isolation pursuant to a formal decision, either where:

1. a court orders the isolation of a remand prisoner if required for the purposes of the investigation; or
2. the prison decides to exclude a prisoner from association with others; or
3. the prison decides to place a prisoner in a security cell or restraint bed.

*Self-isolation:* Where prisoners refrain from contact with others, for example because of fear of other prisoners or mental health problems.

*De facto isolation:* Situations where prisoners are locked in their cells for large parts of the day due to the prison's resource situation. Such confinement occurs without being caused by the prisoner's own behaviour and without a decision from the court or the prison.

### ▶ Finding 9: Inadequate supervision of prisoners held in isolation

In almost all the prisons, there were examples of prisoners held in isolation who did not receive daily supervision from healthcare personnel. In several places, healthcare services lacked knowledge and awareness of the health-related consequences of isolation.

***Remand prisoners placed in isolation by court order***

In several of the prisons we visited, healthcare personnel did not provide daily medical supervision of prisoners who had been subjected to full isolation by court order. For most prisoners, remand detention entails considerable uncertainty and high levels of stress, and many experience it as a life crisis. In such a situation, isolation represents a substantial additional burden. The court may also order that the isolation include restrictions on media access, correspondence and visits. Isolation may continue for long periods and be extended repeatedly.[53] All these factors create a high degree

53 Act of 22 May 1981 No. 25 relating to Criminal Procedure (the Criminal Procedure Act), section 186a, second paragraph cf. third paragraph (a) or (b).

of stress and unpredictability for prisoners placed in isolation by court order.

> "One prisoner who had been excluded from association for almost two months had only been asked three times during that period whether he wished to speak with healthcare personnel. When the prisoner himself requested a medical appointment, he was given an appointment three weeks later. This appointment was subsequently cancelled and the consultation with the doctor took place almost a month after he had originally requested contact with the healthcare services. The healthcare unit justified this by referring to the extensive security measures surrounding the prisoner and the fact that the Correctional Service therefore lacked the capacity to escort the prisoner to the healthcare unit's premises. The possibility of healthcare personnel visiting the prisoner in his cell did not appear to have been considered."
>
> Extract from the Parliamentary Ombud (2024), Report from the visit to Ringerike Prison, p. 62.

It is highly concerning that healthcare services do not ensure daily supervision in these situations. Healthcare personnel also play an important role in ensuring that courts are properly informed about the impact of isolation on the prisoner's health when deciding whether the isolation should continue.

***Prisoners excluded from association by prison decision***

In several prisons, we found that prisoners who had been formally excluded from association were not supervised daily by healthcare services. In some cases, there was no follow-up from healthcare services even when prisoners had been isolated for long periods, in some cases for several weeks. A clinical justification for the low frequency of supervision was rarely documented in prisoners' medical records.

In some prisons, there was also no healthcare supervision of prisoners excluded from association in so-called "reinforced cells".[54]

***Prisoners placed in security cells***

Security cells constitute a particularly intrusive and burdensome form of isolation.[55] The security cell is constructed in concrete, with smooth walls, a plastic mattress and a toilet consisting of a hole in the floor. The design of the cells may cause prisoners to become disoriented after a short period of time. A security cell has characteristics that intensify all the harmful elements of isolation. Prisoners placed in security cells are deprived of almost all control over their own situation and are entirely dependent on staff to safeguard their health and welfare.

In a majority of the prisons, healthcare services had not carried out daily supervision of all prisoners held in security cells. In several cases, it took a long time before prisoners received healthcare supervision after being placed in a security cell, and in some cases there was no healthcare supervision for several days. When prisoners are placed in security cells during evenings, nights or weekends, this is in most prisons outside the healthcare unit's opening hours. In such cases, out-of-hours emergency medical services are responsible for carrying out supervision. It occurred relatively frequently that the emergency medical services did not attend when contacted. In some cases, the emergency medical services were not contacted by the prison at all.

In two prisons, we uncovered several instances where pepper spray (OC spray) had been used against prisoners in connection with placement in security cells, and where either there was documentation showing that it took a long time before healthcare personnel attended, or documentation of healthcare assistance was missing altogether. In these cases, it was unclear whether this was due to the prison failing to inform healthcare services about the use of force.

54 A "reinforced cell" is a cell with reinforced furnishings designed to make it difficult for prisoners to harm themselves or damage furniture and fittings. There is no central specification for how a reinforced cell should be designed, but it may be equipped with shatterproof steel bathroom fixtures, furniture fixed to the floor or of substantial weight, and rounded corners. Such cells will in many cases contain far less furniture and sensory stimulation than an ordinary cell.

55 Parliamentary Ombud (2025). *Security Cells in Prisons: Thematic Report 2025*.

Prisoners exposed to pepper spray in prison require healthcare assistance in many cases, and it is serious that prompt supervision by healthcare personnel is not carried out in such situations. The ECtHR has established that prisoners subjected to pepper spray are entitled to immediate access to healthcare.[56] In one prison, it emerged that a prisoner had on two occasions been kept in handcuffs while inside a security cell. On one of these occasions, he had also been sprayed with pepper spray. The findings concerning the use of pepper spray and handcuffs also illustrate the importance of healthcare personnel promptly supervising prisoners held in security cells.

***Causes of inadequate supervision of prisoners held in isolation***

Our investigations of healthcare services showed that there were several reasons why daily supervision of prisoners held in isolation was not carried out.

In some of the healthcare units we visited, there were no procedures for supervision. In others, written procedures existed, but these did not require daily supervision or failed to describe how supervision should be ensured outside the healthcare unit's opening hours. In one prison, the procedure stated that prisoners should only be supervised weekly or if they themselves requested it. This is clearly contrary to international minimum standards and guidance from the Norwegian Directorate of Health.

Another important reason for the lack of supervision was that healthcare services had not been informed about which prisoners were held in isolation. Under the Execution of Sentences Act, a doctor must be notified without undue delay when a prisoner is excluded from association.[57] The manner in which the healthcare units we investigated received information about prisoners being excluded from association varied, and in several places the procedures were inadequate.

The vast majority of healthcare units kept records of remand prisoners placed in isolation by court order, but some healthcare units kept no such records. Several healthcare units also failed to keep records of prisoners placed in isolation by prison decision. When healthcare services do not keep track of who is isolated and for how long the isolation has lasted, it is clearly difficult to ensure that isolated prisoners receive daily supervision. Several healthcare units also kept no records of prisoners who self-isolated.

In several prisons, we found that failures in prison procedures meant that healthcare services were not always notified, or were notified late. One important reason for the lack of supervision in security cells was that out-of-hours emergency medical services did not carry it out when the healthcare unit was closed. Often, it appeared that the emergency medical services did not consider attendance necessary unless there were reports of acute injury or illness. We saw examples where the emergency medical services assessed supervision as unnecessary on the basis of the prison's description of the prisoner's condition. In some cases, these assessments also concerned prisoners who had been placed in security cells following self-harm or suicide attempts.

It is a matter of serious concern that prison staff make decisions that may prevent prisoners from receiving the healthcare to which they are entitled. In its report following its visit to Norway, the CPT expressed concern about the placement of self-harming prisoners in security cells and stressed that healthcare personnel must visit such prisoners immediately.[58]

***Lack of knowledge about de facto isolation in prisons***

Knowledge about the prison's use of isolation is necessary if healthcare personnel are to work systematically to prevent and limit harm caused by isolation-like conditions. In some places, both the municipal healthcare and care services and the local specialist healthcare services lacked knowledge about the actual extent of confinement within the prison. We found examples where staff and management in healthcare units were unaware of how many hours prisoners in fact spent locked in their own cells during everyday prison life.[59] This contributed to our finding in several prisons that healthcare units did not work systematically to limit or prevent harm caused by ordinary lock-up practices.

56 ECtHR Ali Güneş v. Turkey, 10 April 2012, application no. 9829/07, paras. 40–41 and CPT/Inf (2009) 8.

57 Act of 18 May 2001 No. 21 relating to the Execution of Sentences etc. (the Execution of Sentences Act), section 37, seventh paragraph. In Proposition 165 L (2024–2025), the duty to notify is proposed to be extended to include decisions concerning the use of security cells and restraint beds.

58 CPT (2025). Report to the Norwegian Government on the Visit to Norway, CPT/Inf (2025) 3, para. 123.

59 The Parliamentary Ombud has expressed concern about the high degree of de facto isolation in high-security prisons; see Parliamentary Ombud, Special Report to the Storting on Isolation and Lack of Human Contact in Norwegian Prisons (Document 4:3 (2018/19)); Parliamentary Ombud (2025). Special Report to the Storting on Lock-up and De Facto Isolation in Prisons, Document 4:1 (2024/25)

### ▶ Finding 10: Weaknesses in the supervision of prisoners held in isolation

Prisoners are entitled, like everyone else, to the confidential handling of healthcare information. Both the Mandela Rules and the European Prison Rules emphasise that ordinary rules of medical confidentiality must be maintained when prisoners are in contact with healthcare personnel.[60] This means that prisons should, within the limits of what is compatible with security requirements, facilitate opportunities for prisoners held in isolation to speak with healthcare personnel without being overheard by others.

In many cases, we found that prison officers were present during healthcare personnel's supervision of prisoners who had been excluded from association or isolated by court order. Sometimes these supervisory visits took place with the cell door open, while in other cases they were conducted through the hatch in the cell door. Both the fact that prison officers may overhear conversations between prisoners and healthcare personnel, and the fact that healthcare supervision is conducted through a hatch without healthcare personnel being able to carry out a full assessment of the prisoner's condition, reduce the quality of healthcare supervision. It is therefore crucial that such restrictions are imposed only where necessary for security reasons. Our findings suggested that routines, rather than individual assessments, often formed the basis for such arrangements.

When healthcare personnel carried out supervision in security cells, prison officers and often a supervising officer were always present. The fact that prisoners are unable to share information confidentially with healthcare personnel reduces the quality of healthcare personnel's ability to make sound healthcare assessments. It is also problematic because it significantly limits prisoners' ability to report disproportionate use of force by prison officers.

In addition, these healthcare supervisory visits were most often conducted through the hatch and, in some cases, through a glass panel. We saw several examples where supervision by healthcare personnel was carried out through a small hatch in the cell door, a hatch near floor level, or through a glass window. This makes it difficult for healthcare personnel to observe the patient's physical condition and appearance or to check vital signs. It limits the ability to make proper clinical assessments of the patient's condition.

### ▶ Finding 11: Deficiencies in record-keeping relating to supervision

Healthcare services and the Correctional Service are each required to document the supervision of prisoners held in isolation in their respective record systems.

In several cases, healthcare records lacked documentation of the healthcare unit's follow-up of prisoners held in isolation. In some instances, the prison records stated that "healthcare" had carried out supervision, without the supervision being documented in the prisoner's medical records. Outside normal opening hours, discharge summaries from out-of-hours emergency services were often missing, and healthcare units frequently failed to document the supervision provided. Sometimes there was only a reference to the emergency medical services having conducted supervision, without the results being recorded in the prisoner's medical records. In other cases, records from the emergency medical services had been scanned into the prisoner's medical records without any indication of how the healthcare unit had followed up the findings and assessments made by the emergency medical services.

The healthcare unit's records were often brief and lacked detailed descriptions of the prisoner's health condition or of how the isolation could affect that condition. Examples included notes such as "supervision carried out through hatch – no remarks" or "all ok". The records also frequently lacked information about when the isolation began and how long it was intended to last. In several places, we found no evidence of any assessment or evaluation of the negative health effects of the use of security cells during supervision, including in the case of prisoners with known health problems.

Weak documentation and inadequate record-keeping make it difficult to assess whether the health condition and rights of prisoners held in isolation are being safeguarded. Other factors that may affect prisoners' health, such as placement in a "reinforced cell", with reduced sensory stimulation and fewer opportunities to

60 See European Prison Rules (2020), Rule 42.3(a), and Mandela Rules (2015), Rule 40.

maintain control over their own situation, were also rarely mentioned in healthcare records.

Healthcare records concerning prisoners held in security cells rarely contained descriptions of the security cells themselves. There was often no discussion of how the physical design of the cells affected prisoners' health conditions, including the lack of sensory stimulation and opportunities for self-care. Nor was it documented that prisoners received food through the hatch at floor level and had no opportunity to maintain personal hygiene. The physical and hygienic conditions may have health-related consequences for prisoners, and it is therefore important that healthcare records document the physical conditions resulting from the use of coercive measures.

Taken together, the findings gave the impression that healthcare services do not actively and independently assess whether the use of isolation and security cells may be harmful to the health of the individual prisoner.

## 4.4 Role awareness and independence

It is a fundamental principle that healthcare personnel must not be involved in the prison's use of coercive measures, but rather follow up any harmful effects through healthcare assistance and documentation. It is therefore important that healthcare personnel have a clear understanding of their role and work on the basis of professional independence from the prison.

In prisons, healthcare personnel must fulfil the same role as in the wider community: to provide healthcare and not cause harm. In addition, healthcare personnel are responsible for reporting situations where prison conditions create a risk of health-related harm or where prisoners are subjected to use of force that has caused or may cause health-related harm.

### ▶ Finding 12: When healthcare personnel fail to report concerns

Healthcare personnel must notify prison management about conditions that may be harmful to health and may constitute breaches of prisoners' right to healthcare.[61] Healthcare personnel are also under a duty to notify supervisory authorities of conditions relevant to patient safety.[62] In several cases, prisoners with major and serious needs had been subjected to highly burdensome prison conditions without this being reported. This concerned both physical and mental health conditions.

Healthcare providers are required to notify the Norwegian Board of Health Supervision and the Norwegian Healthcare Investigation Board of very serious incidents.[63] Suicides or suicide attempts must always be reported if they occur while a patient is receiving healthcare or shortly after contact with healthcare services. Our investigation into suicides and suicide attempts from 2022 showed that prison healthcare services report suicides and suicide attempts far too infrequently.[64]

### ▶ Finding 13: Healthcare personnel risk endorsing the prison's use of coercive measures

In some cases, healthcare personnel had been involved in advising prisons on placement in reinforced cells, security cells and restraint beds. This is incompatible with their independence and role as healthcare personnel. We also found cases where healthcare personnel had written, both in their own records and in the prison's supervision logs, that they considered placement in a security cell to be "justifiable". Healthcare personnel must neither approve nor recommend the use of coercive measures by the Correctional Service (see also Finding 16: Deficiencies in cooperation between primary healthcare services, specialist healthcare services and the Correctional Service).[65]

61 Mandela Rules (2015), Rules 33 and 35. See also the International Covenant on Economic, Social and Cultural Rights (1966), Article 12.

62 See section 17 of the Health Personnel Act.

63 Health and Care Services Act, section 12-3a; Specialist Healthcare Services Act, section 3-3a, cf. the Act of 16 June 2017 No. 56 relating to State Supervision of Health and Care Services etc. (the Health Supervision Act), section 6.

64 Parliamentary Ombud (2022). *Suicides and Suicide Attempts in Prison: An Investigation under the OPCAT Mandate*, pp. 20–21.

65 Mandela Rules (2015), Rule 46.1.

### ▶ Finding 14: Lack of documentation of injuries resulting from disproportionate use of force

Documenting and reporting injuries that a prisoner may have sustained during arrest, police custody or imprisonment is an important safeguard of legal protection and contributes to reducing the risk of inhuman treatment.[66] This is a task that requires attentiveness, competence and role awareness on the part of healthcare personnel.

Not all healthcare units ensured that examinations were carried out to determine whether injuries had occurred in connection with admission to prison. Several healthcare units did not have access to cameras to document injuries that may have occurred during arrest, admission or transfer from other prisons. Several also demonstrated limited awareness of their responsibility to identify disproportionate use of force. The CPT has repeatedly criticised the Norwegian authorities for an inadequate system for documenting injuries and considers there to be a high risk that such injuries are not detected and investigated in Norwegian prisons.[67]

Some prisoners in Norwegian prisons have been subjected to torture and inhuman treatment abroad. Experiences of torture may lead to physical and psychological health problems that make life in prison particularly difficult. In addition, prisoners with experiences of torture may have specific rights, including the right to rehabilitation.[68] Healthcare personnel generally demonstrated low levels of competence and awareness in this area.

## 4.5 Organisational factors affecting prisoners' healthcare needs

Municipalities are responsible for providing healthcare and care services to prisoners.[69] Municipalities with prisons receive annual grants through the national budget for healthcare and care services for prisoners.[70] It is up to each individual municipality how it organises healthcare and care services for prisoners. Both the European Prison Rules and the Mandela Rules emphasise that healthcare services for prisoners must be of the same standard as those available outside prison. They must also be organised in close cooperation with the wider public healthcare services in such a way as to ensure continuity of treatment.[71]

### ▶ Finding 15: Out-of-hours medical supervision of prisoners held in isolation is inadequate

Outside the healthcare unit's opening hours, out-of-hours emergency medical services generally had to be contacted where healthcare assistance was required. Opening hours were usually limited to daytime on weekdays. In one prison, the healthcare unit was also open during daytime hours at weekends. Our experience is that the way municipalities organise healthcare services outside the healthcare unit's opening hours is decisive for whether prisoners held in isolation receive the healthcare to which they are entitled. The organisa-

66 CPT (2025). *Healthcare in Prison: Prison Standard*, CPT/Inf (2025) 37, paras. 15–24; CPT (2013). *Documenting and Reporting Medical Evidence of Ill-treatment*, extract from the CPT's 23rd General Report (2013), CPT/Inf (2013); UN Subcommittee on Prevention of Torture, Report on the Visit to the Maldives (2009), CAT/OP/MDV/1, p. 6, para. 112.

67 CPT (2025). Report to the Norwegian Government on the Visit to Norway, CPT/Inf (2025) 3, paras. 110 and 114; CPT (2019). Report to the Norwegian Government on the Visit to Norway, CPT/Inf (2019), paras. 91–95.

68 The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), Article 14, establishes that victims of torture are entitled to fair and adequate compensation, including the means for as full rehabilitation as possible.

69 Health and Care Services Act, section 3-9.

70 Norwegian Directorate of Health (2019). *Healthcare and Care Services for Prisoners – Annual Report 2018*.

71 European Prison Rules (2020), Rec(2006)2-rev, Rules 40.1, 40.2, 40.3 and 40.4; Mandela Rules (2015), Rules 24.1 and 24.2.

tion of municipal healthcare and care services may affect how, and whether, isolated prisoners receive the necessary care. In some cases, the prison healthcare unit is organised directly under the out-of-hours emergency medical services; in other cases, it is organised as a separate municipal unit with either close or only sporadic cooperation with the emergency medical services.

Managers with a wide span of control, high staff turnover and challenges in cooperation between different municipal units may affect collaboration between prison healthcare units and out-of-hours emergency medical services. Emergency medical services must have the resources and expertise required to assess when it is necessary to attend prisoners in prison, for example for supervision in security cells. We have seen several examples where emergency medical services did not attend for supervision because they assessed that there was no need for acute healthcare assistance. International minimum standards require daily medical supervision of prisoners (see Finding 9: Inadequate supervision of prisoners held in isolation), regardless of how healthcare services are organised in the individual country.

### ▶ Finding 16: Deficiencies in cooperation between primary healthcare services, specialist healthcare services and the Correctional Service

Prisoners are entitled to necessary healthcare in specialist healthcare services on the same basis as others.[72] Where necessary, the municipally employed prison doctor sends a referral to the hospital normally used by the municipality. In 2020, the Ministry of Health and Care Services instructed the regional health authorities to prepare a plan for establishing a dedicated specialist healthcare function within mental healthcare services and interdisciplinary specialised substance abuse treatment (TSB). The purpose was to ensure on-site specialist healthcare services for prisoners.

There was considerable variation in the presence of specialist healthcare services in the nine prisons where we examined this issue. In several prisons, vacancies and staff turnover negatively affected the services available to prisoners.

There was also considerable variation in the cooperation between municipal healthcare services and specialist healthcare services, and in whether specialist healthcare services provided guidance to prison healthcare units.[73] In some places, specialist healthcare services provided regular group supervision to prison staff on issues such as suicide risk and psychosis.

Healthcare personnel working in prisons depend on information from the prison in order to perform their duties. This requires continuous and structured cooperation between healthcare services and the prison at all levels, from day-to-day work with individual patients through to management level. At the same time, healthcare personnel have a responsibility to maintain their independence from the prison and to uphold their role as healthcare professionals in their interactions with prisoners. Close and collegial cooperation between healthcare personnel and prison officers may be positive, but it may also lead to "institutional blindness" and inappropriate blurring of roles.

The distribution of medication raises particular challenges. In most cases, prisoners are not permitted to store or administer medication themselves for security reasons. Medication is therefore prepared by healthcare personnel and handed over to prison officers, who distribute it to prisoners. Such an arrangement entails a risk of failures at several stages.

In a majority of the prisons we investigated, we observed that medication was stored unlocked in prison officers' staff rooms. This increases the risk of medication going missing and at the same time makes it difficult to determine what has happened when errors occur in medication dispensers. Medication-related incidents were generally common in several of the prisons we visited. In the material we reviewed, we saw examples of prisoners being given medication belonging to other prisoners and of a prisoner managing to overdose on accumulated medication. In some prisons, medication was distributed in communal areas and in the presence of several prisoners. This may create a risk of threats against prisoners receiving, for example, sedatives or stimulant medication, and of medical information being disclosed.

72 Patients' and Users' Rights Act, section 2-2.

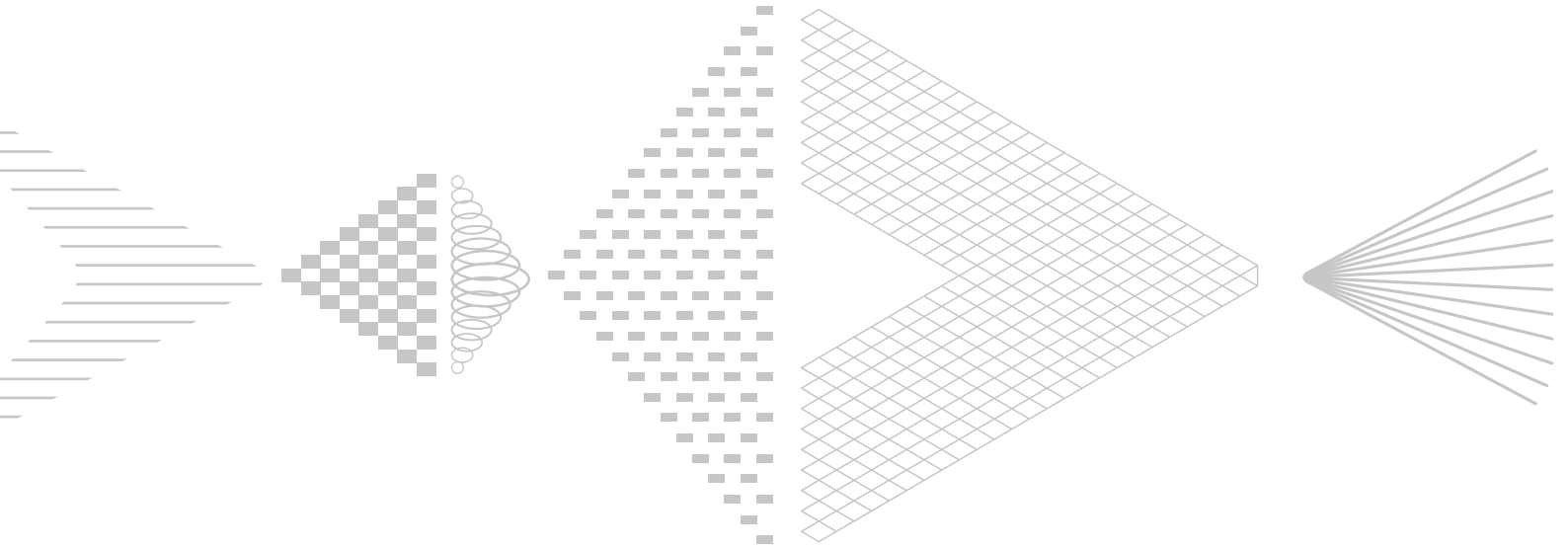
73 The duty of specialist healthcare services to provide guidance to municipal healthcare and care services follows from the Specialist Healthcare Services Act.

The healthcare unit must provide training to the prison in the handling of medication and must monitor and guide the prison if it becomes aware of errors in medication management.

In its 2025 report, the CPT was critical of the organisation of healthcare services for prisoners. Among other things, the Committee stated that it had "strong reservations" about the organisation and coordination of healthcare services in Norwegian prisons.[74] The CPT identified staff turnover, insufficient cooperation between different levels of healthcare services, multiple record systems and a general lack of coordination between service providers as the main challenges.

Our visits have revealed a need for closer and more systematic cooperation between prison healthcare units, specialist healthcare services and prisons, both at management level and in day-to-day work. Better cooperation between the parties may reduce the risk of prisoners' health being harmed during imprisonment, for example through joint projects aimed at prevention, reduction of coercive measures and competence development. A lack of systematic cooperation has serious consequences for prisoners with particularly extensive care needs (see Finding 6: Inadequate care of prisoners with extensive healthcare needs or suicide risk).

Our findings and the international criticism indicate that the authorities have not sufficiently recognised the complexity of the responsibilities that prison healthcare services should fulfil.



74 CPT (2025). Report to the Norwegian Government on the Visit to Norway, CPT/Inf (2025) 3, para. 109.

# 5. Three main challenges facing healthcare services for prisoners

In the Parliamentary Ombud's assessment, the findings described in this report are largely linked to three overarching challenges:

## 1. Insufficient knowledge about prisoners' health problems and prison conditions

First, the level of expertise among healthcare personnel is too low, both regarding prisoners' health problems and prison conditions that may affect their health situation. Lack of knowledge contributes, among other things, to failures to ensure daily supervision of prisoners held in isolation and to follow up concerns relating to prison conditions or disproportionate use of force. Healthcare personnel providing healthcare in prisons must have expertise in the factors that make prisoners' health situations distinct: the combination of high levels of illness, limited autonomy, the use of coercive measures and extensive isolation.

## 2. Healthcare services are not staffed adequately to safeguard prisoners' healthcare rights

Second, staffing levels within the municipal healthcare and care services providing services to prisoners are too low to deliver the healthcare services to which prisoners are entitled under international minimum standards. Prison healthcare units are not staffed adequately to carry out preventive healthcare work, such as supervision of prisoners held in isolation, thorough admission interviews and follow-up of how general prison conditions affect prisoners' health. In the vast majority of prisons, healthcare units are not staffed to provide services during evenings and weekends. This places greater responsibility on out-of-hours emergency medical services, but these services provide only limited follow-up of prisoners' needs outside the healthcare units' opening hours. This contributes to the failure of healthcare services to safeguard the needs of prisoners held in isolation. We also observe that staffing shortages within the Correctional Service create a risk that prisoners are unable to attend healthcare appointments outside the prison.

## 3. Insufficient cooperation between the Correctional Service and healthcare services

Third, cooperation between the Correctional Service, healthcare and care services, and specialist healthcare services is too weak. Cooperation between different municipal bodies, between primary and specialist healthcare services, and also between healthcare services and the Correctional Service, must be organised in such a way that prisoners receive the healthcare to which they are entitled. This is important, for example, in connection with transfers between prisons, release and discharge from specialist healthcare services. We are particularly concerned that prisoners who are so seriously mentally ill that they should have been admitted to hospital remain in prison without adequate treatment and without the relevant authorities being able to identify this.

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