National Preventive Mechanism

Optional Protocol to the UN Convention
against Torture and Other Cruel, Inhuman
or Degrading Treatment or Punishment

Annual Report 2016

PARLIAMENTARY OMBUDSMAN OF FINLAND

The Finnish National Preventive Mechanism against Torture and Ill-Treatment

Annual Report 2016

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TO THE READER

The Parliamentary Ombudsman has acted as the National Preventive Mechanism (NPM) under the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) for two full years. The activities have been discussed in separate sections of the Ombudsman's annual reports for 2015 and 2016. These overviews are complemented by the present report, published in English, on the activities of the NPM in 2016.

In Finland, the Parliamentary Ombudsman has a strong mandate in matters concerning fundamental and human rights, and the Ombudsman is part of Finland's National Human Rights Institution (NHRI) established according to the Paris Principles. Inspection visits to closed institutions have been one of the Ombudsman's special tasks even before receiving the NPM mandate. However, oversight of the treatment of people deprived of their liberty has further diversified under the OPCAT. Oversight of legality has been complemented with a preventive approach and constructive dialogue with public authorities and the staff of institutions. These elements have been present in the Ombudsman's inspection visits long before NPM duties, but the new mandate has further emphasised their importance.

Visits and the related activities are an effective tool and a central area of focus for the Office of the Parliamentary Ombudsman. The use of external experts on visits has expanded the NPM's expertise, helped view issues from various viewpoints and diversified dialogue. International cooperation and training activities have also increased substantially.

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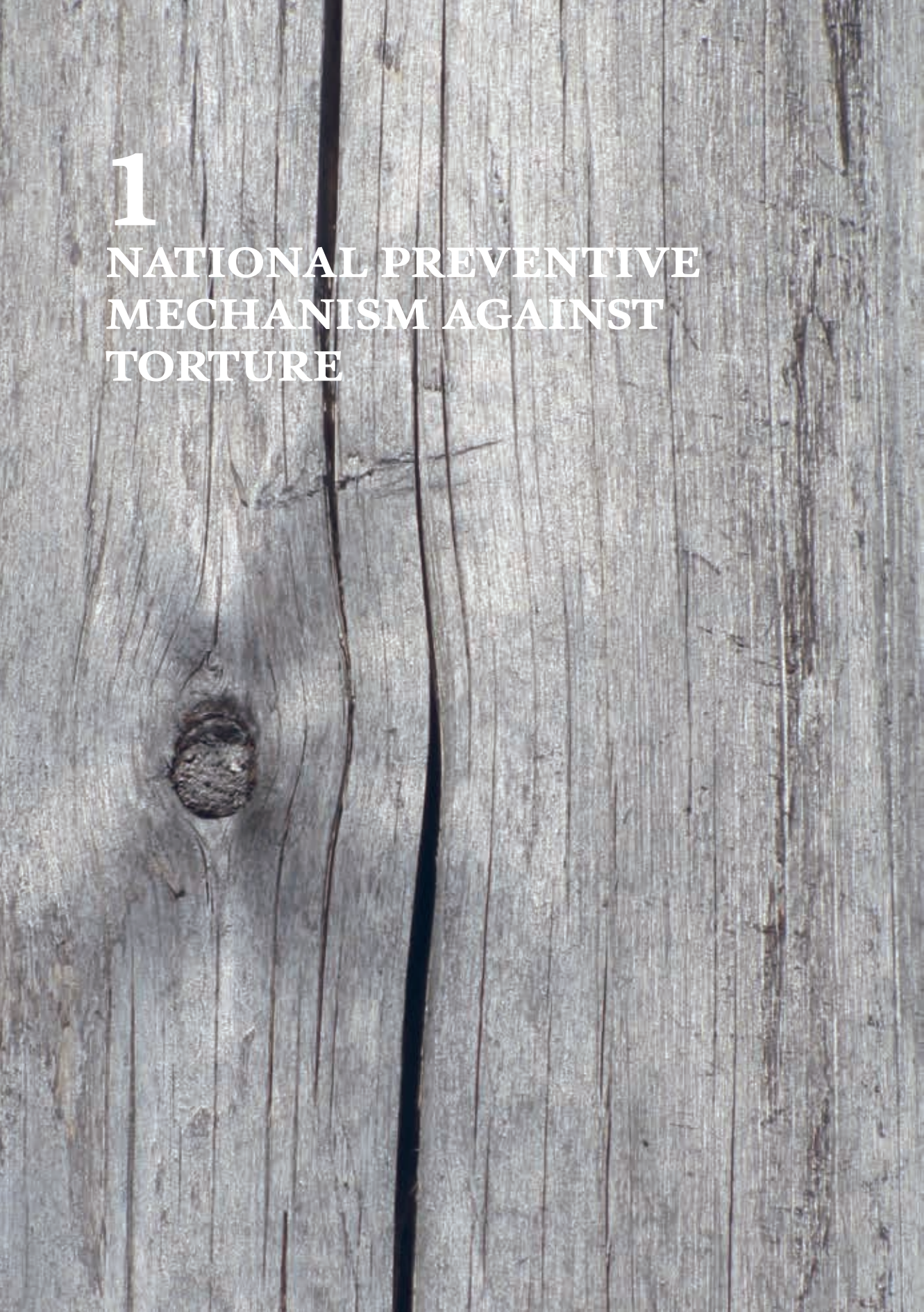


1
NATIONAL PREVENTIVE MECHANISM AGAINST TORTURE

1.1 The Ombudsman's task as a National Preventive Mechanism

On 7 November 2014, the Parliamentary Ombudsman became the Finnish National Preventive Mechanism (NPM) under the Optional Protocol of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The Human Rights Centre (HRC) and its Human Rights Delegation, which operate at the Office of the Parliamentary Ombudsman, help fulfil the requirements laid down for the NPM in the OPCAT, which makes reference to the so-called Paris Principles.

The NPM is responsible for conducting visits to places where persons are or may be deprived of their liberty. The scope of the OPCAT has been defined as broadly as possible. It includes prisons, police departments and remand prisons, but also places like detention units for foreigners, psychiatric hospitals, residential schools, child welfare institutions and, under certain conditions, care homes and residential units for the elderly and persons with intellectual disabilities. The scope covers, in all, thousands of facilities. In practice, the NPM's visits mean, for instance, visits to care homes for elderly people with memory disorders, where the objective is to prevent the poor treatment of the elderly and violations of their right to self-determination.

The OPCAT emphasises the NPM's mandate to prevent torture and other prohibited treatment by means of regular visits. The NPM has the power to make recommendations to the authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty and preventing actions that are prohibited under the Convention against Torture. It must also have the power to submit proposals and observations concerning existing or draft legislation.

Under the Parliamentary Ombudsman Act, the Ombudsman already had the special task of carrying out inspections in closed institutions and overseeing the treatment of their inmates. However, the OPCAT entails several new features and requirements with regard to visits.

In the capacity of the NPM, the Ombudsman's powers are somewhat broader in scope than in other forms of oversight of legality. Under the Constitution of Finland, the Ombudsman's competence only extends to private entities when they are performing a public task, while the NPM's competence also extends to other private entities in charge of places where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence. This definition may include, for example, detention facilities for people who have been deprived of their liberty on board a ship or in connection with certain public events as well as privately controlled or owned aircraft or other means of transport carrying people deprived of their liberty.

International bodies have considered it advisable to organise the work of the NPM under a separate unit. At the Office of the Parliamentary Ombudsman, however, it has seemed more appropriate to integrate the tasks of the NPM into the work of the Office as a whole. Several administrative branches have facilities that fall within the scope of the OPCAT. However, there are differences between the places, the applicable legislation and the groups of people who have been deprived of their liberty. Therefore, the expertise needed on visits to different facilities also varies.

As any separate unit within the Office of the Ombudsman would in any case be very small, it would be impossible to assemble all the necessary expertise in such a unit and the number of visits conducted would remain considerably smaller. Participation in the visits and the other tasks of the Ombudsman, especially the handling of complaints, are mutually supportive activities. The information obtained and experience gained during visits can be utilised in the handling of complaints, and vice versa. For this reason, too, it is important that those members of the Office personnel whose area of responsibility cover facilities that fall within the scope of the OPCAT also participate in the tasks of the NPM. In practice, this means the majority of the Office's legal advisers, *i.e.* some 25 people.

The OPCAT requires the States Parties to make available the necessary resources for the functioning of the NPM. The Government proposal concerning the adoption of the OPCAT (HE 182/2012 vp) notes that in the interest of effective performance of obligations under the OPCAT, the personnel resources at the Office of the Parliamentary Ombudsman should be increased. Regardless of this, no additional personnel resources have been granted for the Ombudsman to perform the duties of the NPM.

In the report on its visit to Finland in 2014, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) recommended that steps be taken to increase significantly the financial and human resources made available to the Finnish Parliamentary Ombudsman in his role as the NPM. The Committee also suggested that consideration be given to setting up a separate unit or department within the Office of the Parliamentary Ombudsman to be responsible for the NPM functions.

In budget proposal for 2014, the Ombudsman requested that funding for one new post focusing on supervisory tasks be added to the Office's operating appropriation. No such addition was made. To save costs, the Ombudsman did not propose a new post of a legal adviser in his budget proposal for 2015. In the budget proposal for 2016, the Ombudsman has again requested funding for establishing one post of a legal adviser to discharge the duties of the NPM. No additional funding was allocated for this purpose.

In its recommendations issued in December 2016 on the basis of Finland's seventh periodic report, the UN Committee against Torture (CAT) expressed its concern for the Ombudsman's insufficient financial or human resources to carry out the mandate of the NPM. The CAT recommended that the State should strengthen the NPM by providing it with sufficient resources to enable it to carry out its mandate independently and efficiently. The CAT also recommended that Finland should give consideration to the possibility of establishing the NPM as a separate entity under the Parliamentary Ombudsman. The State has been requested to provide a response to the recommendations by 7 December 2017.

1.2 Operating model

The tasks of the National Preventive Mechanism have been organised without setting up a separate NPM unit in the Office of the Parliamentary Ombudsman. Two public servants at the Office have been assigned to coordinate the NPM duties for a fixed term in addition to their other tasks. The coordinators are responsible for the international relations of the NPM and for internal coordination within the Office. This arrangement will be in force until the end of 2017. Even though new human resources have not been made available, the plan is to have one legal adviser focus full time on coordinating the tasks of the NPM. In the summer of 2016, the Office employed a trainee who focused, in particular, on the work of the NPM.

The Ombudsman has also appointed an OPCAT team within the Office. Its members are the principal legal advisers working in areas of responsibility that involve visits to places where persons are or may be deprived of their liberty, as referred to in the OPCAT, or where customers' freedom is or may be restricted. The team has nine members, and it is led by one of the NPM coordinators. In 2016, the OPCAT team reviewed and discussed, among other things, experiences gained from the use of external experts and matters related to visits (*e.g.* conducting follow-up visits and visits outside office hours).

In the autumn of 2016, induction training was provided to new external experts regarding the visits undertaken by the NPM. Previously, only one external expert had participated in the visits. After the training, the NPM has been able to use a total of eight external experts, all of whom have a background in health care: three psychiatrists (one of whom also specialises in adolescent psychiatry), one specialist in forensic psychiatry, two medical specialists in geriatrics, one medical specialist in intellectual disabilities and one psychiatric nurse. At the beginning of 2017, training has also been provided to three experts by experience whose expertise will be used during visits to closed social welfare institutions for children and adolescents.

During the visits conducted by the NPM, efforts have been made to engage more frequently in constructive dialogue with the staff regarding good practices and procedures. Feedback on observations as well as guidance and recommendations may also be given to the supervised entity already during the visit. At the same time, it has been possible to discuss amiably how the facility could, for example, correct the inappropriate practices observed.

A report is drawn up after each visit, presenting the observations made during the visit. The draft report is often sent to the facility visited to provide it with the opportunity to comment on the observations and notify any measures taken in response. After that, the facility may also be requested to notify by a given deadline the measures it will take in relation to those observations that have not yet been dealt with. If, during a visit, something has arisen that needed investigating, the Ombudsman has taken up the investigation of the matter on his/her own initiative and the issue has not been discussed further in the report.

2
ACTIVITIES

2.1 Visits

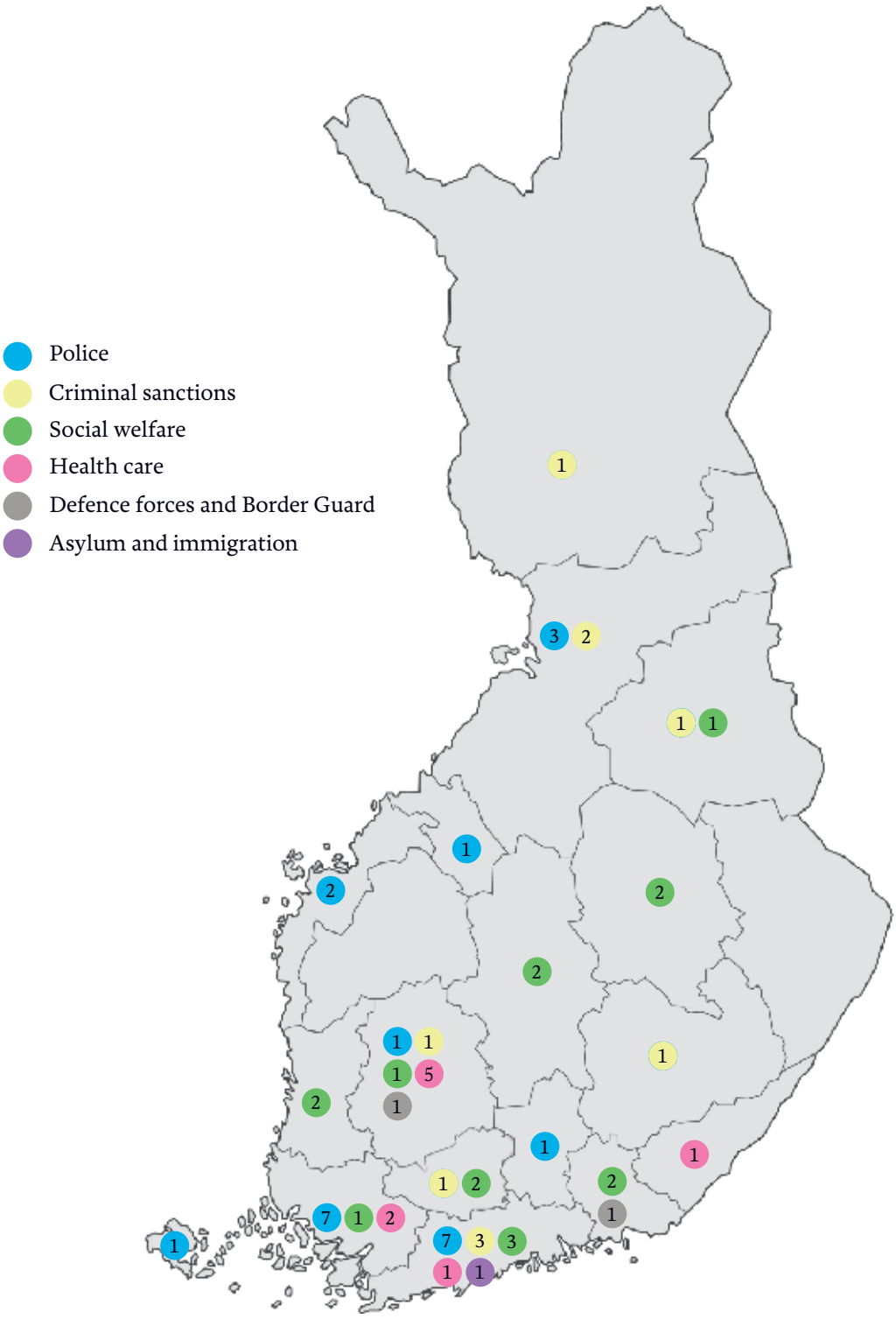
The role of an NPM requires conducting regular visits. The Office of the Parliamentary Ombudsman has made a conscious effort to increase the number of visits carried out. In 2014, the Office carried out a total of 111 visits, which was nearly 25 per cent more than in the year before. During 2015, the NPM's first full year of operation, the Office conducted a total of 152 visits, of which 82 within the NPM mandate. A clear majority of these were carried out unannounced. Visits conducted outside the mandate of the NPM may concern facilities that closely resemble the places visited in the role of the NPM (*e.g.* certain residential units for the elderly and reception centres for asylum seekers).

In the second year of operation, it was no longer possible to increase the number of visits without additional human resources. The aim has been to ensure that the quality of visits remains high because that has an impact on their effectiveness. In 2016, the total number of visits was 115, of which 56 were carried within the mandate of the NPM. A few follow-up visits were also conducted during the year. Of all visits, 31 were carried out completely unannounced. One facility was notified in advance that the visit would be conducted during the next two months. An external expert participated in seven visits, which were targeted at the following units: geriatric psychiatry wards of a psychiatric hospital, a psychiatric hospital, psychiatric wards of a central hospital, a police prison, a unit for persons with intellectual disabilities, a prison and an outpatient clinic of the Prisoners' Health Care Unit.

So far, the NPM has conducted only a few visits during 'inconvenient' hours, *e.g.* in the evening, at night or during weekends. Evening visits have mainly been made to social welfare units for minors to better ensure the presence of children and adolescents. In the health care sector, visits have been conducted in the evening to inspect the secure rooms of emergency care units. A new collective agreement for public servants has entered into force at the Office of the Parliamentary Ombudsman. The agreement allows compensation to be paid to those who conduct visits outside office hours. This will likely help diversify the times of conducting visits.

The task of the NPM has increased the focus on interviews with persons deprived of their liberty. At the places visited, efforts have been made to interview those who are the most vulnerable, such as foreign nationals. In practice, this has led to an increase in the use of interpreters. Interpreters have participated in particular in visits to prisons and detention units for foreigners. The aim is to establish a separate pool of interpreters for the visits conducted by the NPM, selecting interpreters who are familiar with the environment and the related vocabulary. This will also help improve the quality of interviews.

Effective remedies were the special theme for 2016 in the field of fundamental and human rights at the Office of the Parliamentary Ombudsman. During visits, special attention was given to customers' and their families' access to effective remedies, such as objections, complaints and appeals. The Ombudsman has not yet adopted a special theme for the visits conducted by the NPM. However, individual visits may have focused on specific themes or targeted certain vulnerable groups.



NPM mandate visits 2016 - the list of visits, see annex 2. Finland is one of the most sparsely inhabited country in Europe. Population distribution is very uneven. Most of the population and the places where persons are deprived of their liberty are concentrated on the southern and western part of Finland.

2.2 Information activities

A brochure on the NPM was published in 2016. It is available in Finnish, Swedish, English, Estonian and Russian, and it will be translated into other languages, if necessary.

Full reports on some of the visits conducted by the NPM have been made available on the public website of the Office of the Parliamentary Ombudsman. The aim is to draw up summaries of all visits, presenting the place visited, the aim of the visit as well as the main observations and recommendations. Moreover, the summaries will be updated with information on the measures taken by the facilities in response to the recommendations.

2.3 Cooperation with other operators

In the field of police administration, meetings have been held with representatives from the National Police Board regarding the reform of the act on the treatment of persons in police custody (*laki poliisin säilyttämien henkilöiden kohtelusta* 841/2006), plans to renovate police prisons and the national operational guidance of police prisons. Reports on visits to police prisons have been submitted to the National Police Board for information. Police prisons were also discussed in connection with a visit to the National Police Board.

The police's internal oversight of legality at police departments is conducted by separate legal units. It has been emphasised that these units should also inspect the operations of police prisons in their respective territories. The National Police Board submits to the Parliamentary Ombudsman each year a report on the oversight of legality within its area of responsibility. The report has also been submitted for the year 2016. Among other things, the report indicates that the visits conducted as part of the National Police Board's oversight of legality focused, in particular, on the legal protection of persons deprived of their liberty and more specifically on the provision of information on their rights, notifications of the deprivation of liberty and postponing such notifications, and the legal protection of young persons deprived of their liberty.

The Finnish Border Guard also submits an annual report to the Parliamentary Ombudsman on its internal oversight of legality. The report is drawn up by the Headquarters of the Finnish Border Guard.

In the field of criminal sanctions, reports on visits have been published in full on public websites. All visit reports are sent for information to the Central Administration of the Criminal Sanctions Agency, the management of the criminal sanctions region in question and the Ministry of Justice. The central and regional administration are also often requested to notify the measures taken due to the observations. The Parliamentary Ombudsman, in turn, receives the reports drawn up on the facilities visited as part of the internal oversight of legality in the criminal sanctions field.

In 2016, the Deputy-Ombudsman visited the Central Administration of the Criminal Sanctions Agency to discuss the situation of remand prisoners, facility projects and certain issues concerning the restraint of prisoners. In the most problematic prisons (Riihimäki and Mikkeli), a representative from the relevant Region Centre was invited to participate in the final discussion of the visit.

The Director General of the Criminal Sanctions Agency was invited to participate in a meeting held at one of the prisons to discuss observations made during visits and matters that had emerged from complaints against the prison in question (Riihimäki). The topics discussed included the distance between prisoners and staff, atmosphere problems, the insufficiency of facilities for unsupervised visits, long periods between visits, the cancellation of activities, the closed conditions of students, tight schedules (overlapping activities), limited leisure-time activities, the issuance of decisions concerning the possession of property, and access to the library.

A meeting was also held with Kriminaalihuollon tukisäätiö (Krits), a nationwide non-governmental non-profit aftercare organisation, with a view to begin exchanging information and learn about the work of the organisation's Ombudsman Office for Offenders. Krits visits approximately 10 prisons each year. Thus, it gains plenty of information on the treatment, conditions and health care of prisoners. Since the meeting, Krits has provided the NPM with valuable information before its visits to prisons on the problems that prisoners and their families have reported about the institution in question. Krits, in turn, has been given copies of reports on visits to prisons and outpatient clinics.

In the health care sector, collaboration partners include the National Supervisory Authority for Welfare and Health (Valvira) and regional state administrative agencies (AVI). Before visits, the competent regional state administrative agency is regularly contacted to receive information on its observations about the facility in question. Moreover, the Office of the Parliamentary Ombudsman, Valvira and regional state administrative agencies try to organise a cooperation meeting once a year. The last meeting was held in June 2016. The agenda included the flow of information between the supervisory authorities, collaboration in the supervision of psychiatric hospitals as well as the division of powers and duties in the supervision of prisoners' health care.

Since the beginning of 2016, Valvira and the regional state administrative agencies have also been responsible for supervising the organisation of prisoners' health care. In practice, the supervision tasks have been centralised and assigned to AVI Northern Finland, which conducts guidance and assessment visits to the Prisoners' Health Care Unit independently or together with Valvira. In 2016, the target of 12 visits was achieved. Supervision plans and reports on visits are sent to the Parliamentary Ombudsman for information. In turn, the Ombudsman sends its own supervision plans and reports for information to Valvira and the regional state administrative agency.

In March 2016, legal advisers from the Office of the Parliamentary Ombudsman visited Valvira to agree on collaboration in the supervision of prisoners' health care. Representatives of AVI Northern Finland participated in the discussion via Skype.

The legal adviser responsible for prisoners' health care matters at the Office also met the new director of the Prisoners' Health Care Unit in June. Among other things, the parties agreed on procedures concerning the flow of information.

Before visits to psychiatric units, the NPM has also contacted non-governmental organisations (NGO). During the reporting year, it contacted the National Family Association Promoting Mental Health in Finland (FinFami) and its local associations in the regions of Pirkanmaa and South Karelia.

IN THE FIELD OF SOCIAL WELFARE, reports on visits are often also sent to the relevant regional state administrative agency for information.

2.4 International cooperation

The collaboration of the Nordic NPM network continued with a meeting organised by the Swedish NPM in Stockholm in June 2016. In addition to Swedish representatives, the meeting included participants from the Norwegian, Danish and Finnish NPMs. The Swedish participants also included a psychiatrist who acts as an external expert of the Swedish NPM. The event focused on visits to psychiatric institutions. The NPMs discussed, in particular, their observations about the long periods of seclusion and restraint experienced by psychiatric patients. The participants also visited the Helix psychiatric hospital. It was agreed that the Finnish NPM would organise the next meeting with a focus on the inspection methods used in different countries, interviewing techniques and the use of external experts. The meeting was held in January 2017. A separate training day on interviewing techniques and the use of external experts was organised in connection with the meeting.

In October 2016, Finland hosted a meeting of Baltic and Nordic ombudsmen. The second day of the event was dedicated to discussions on the functions of NPMs. The topic was introduced by Lithuanian and Finnish representatives. The participants also celebrated the 10th anniversary of the OPCAT.

On the international United Nations Day on 24 October 2016, staff from the Office of the Parliamentary Ombudsman participated in an event organised by the Human Rights Centre, the UN Association of Finland and the Ministry for Foreign Affairs on the theme "50 years of UN Human Rights Conventions". One of the purposes of the seminar was to consider how Finland can promote the respect for and implementation of human rights. As one of the speakers, Parliamentary Ombudsman Petri Jääskeläinen discussed the topic "Implementation of fundamental and human rights: the significance of UN human rights conventions".

In October 2016, the Finnish NPM issued a statement to the UN Committee against Torture (CAT) on how the implementation of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has progressed in Finland and how the activities of the NPM have contributed to the imple-

mentation of the Convention. The statement was part of the Committee's consideration of the seventh periodic report of Finland. The delegation of the Finnish NPM, led by the Parliamentary Ombudsman, also met the CAT in a private meeting held in Geneva in November 2016. The delegation stayed for another day to hear the questions that the Committee's rapporteurs addressed to the State of Finland regarding its periodic report. Many of the issues raised were discussed in the NPM's statement to the Committee.

Before the meeting with the CAT, the representatives of the NPM visited the office of the Association for the Prevention of Torture (APT) and met its Chief of Operations Barbara Bernath and other staff. The parties discussed, among other things, the Finnish NPM's statement to the CAT, which the representatives of APT had already familiarised themselves with.

The NPM's report on 2015, its first year of operation, was submitted for information to the CAT and its Subcommittee on Prevention of Torture (SPT). In November 2016, the SPT addressed a few comments and questions to the NPM on the annual report. Overall, the SPT considered the annual report to be of good quality and illustrative. The NPM will send its reply to the SPT during the first part of 2017.

On the second day of their meeting (5 October 2016), Baltic and Nordic ombudsmen focused on the activities of national preventive mechanisms.

In December 2016, the coordinators of the NPM met SPT member Mari Amos, who is the subcommittee's rapporteur for Finland. The parties discussed, among other things, the resources of the NPM and touched upon some of the issues that the SPT had asked about.

In November 2016, the Nordic ombudsmen adopted a joint Nordic letter addressed to the subcommittee. The letter was signed by the ombudsmen of Denmark, Finland, Greenland, Norway and Sweden. In the letter, the ombudsmen expressed their critical view on plans to establish the NPM Observatory, an NGO monitoring the national preventive mechanisms.

2.5 Training

Two public officials from the Office of the Parliamentary Ombudsman attended a three-day training workshop for NPMs organised in Vilnius, in June 2016, by the Lithuanian ombudsman, the International Ombudsman Institute (IOI) and APT. The workshop a follow-up to a similar training organised in Riga the year before. This time the theme was "Monitoring of Psychiatric Facilities".

One of the coordinators at the Office took part in the third Jean-Jacques Gautier NPM Symposium on monitoring psychiatric institutions. The symposium was organised in Geneva by APT in September 2016. In addition to NPMs, the participants included experts by experience and representatives of various NGOs.

In September 2016, two legal advisers from the Office of the Parliamentary Ombudsman specialising in health care issues attended a two-day symposium on reducing risks and preventing violence, trauma, and the use of seclusion and restraint in psychiatric care. The symposium was organised by Niuvanniemi Hospital.

The NPM organised a one-day induction training for its external experts in September 2016. In addition to the Office's own staff, training was provided by psychiatrist Veronica Pimenoff, who has participated in visits conducted by the CPT as a medical expert and has since 2015 also acted as an external expert on the visits of the Finnish NPM.

In September 2016, one of the NPM coordinators participated in an international training event organised in Helsinki. The training concerned best practices in forensic psychiatry, focusing on the theme "Modern forensic in-patient facility design standards". The speakers included Professor Harry Kennedy from Ireland and Architect Christopher Shaw. One of the examples of modern psychiatric hospitals mentioned at the training was the Swedish hospital Helix, which the coordinator had visited in June in connection with the meeting of the Nordic NPMs. The theme is very topical in Finland, because a new hospital complex is being planned in Helsinki. The complex would include a psychiatric hospital and a unit of forensic psychiatry.

In December 2016, the staff of the Office of the Parliamentary Ombudsman were provided with training on the Non-Discrimination Act. The event included a presentation of the Non-Discrimination Ombudsman's activities as the National Rapporteur on Trafficking in Human Beings. Information was also provided on supervising the removal from the country of foreign nationals, *i.e.* the practical supervision carried out by the Non-Discrimination Ombudsman and its effectiveness. The topic was followed up in February 2017 when a representative from the police came to the Office to talk about the challenges associated with the return flights of foreign nationals and the use of force by the police in such situations.

3
KEY OBSERVATIONS, RECOMMENDATIONS AND AUTHORITIES' MEASURES

3.1 Police detention facilities

It is the duty of the police to arrange the detention of persons deprived of their liberty not only in connection with police matters but also as part of the activities of the Customs and the Border Guard. Most of the apprehensions, over 60,000 every year, are due to intoxication. The second largest group concerns persons who are suspected of an offence. A small number of people detained under the Aliens Act are also held in police prisons. Depending on the reason, the duration of detention may vary from a few hours to several months. There are approximately sixty police prisons in Finland. Their sizes and rates of use vary greatly. The largest police departments are currently undergoing a renovation programme.

Within its mandate as the NPM, the Deputy-Ombudsman has conducted dozens of visits to police detention facilities over the past two years. In 2016, 16 visits were made to police prisons. The facilities visited were located in Hyvinkää, Järvenpää, Porvoo (two visits), Vantaa (two visits), Espoo, Lahti, Vaasa, Kokkola, Jakobstad, Ylivieska, Raahe, Oulu, Mariehamn and Tampere. In addition, the operations of two detoxification centres (in Espoo and Tampere) were also examined.

Visits to police prisons are usually unannounced. During the year under review, only one visit to a police prison was pre-announced. The reason for the announcement was to ensure that the doctor of the police prison would be present because an external medical expert also participated in the visit. One police prison was subjected to both a regular visit and a follow-up visit during the same year. The follow-up visit proved useful because the police prison had not effectively implemented all the measures required after the first visit.

The observations and recommendations made during the year under review mainly concerned the same aspects as the year before. The most important issues were related to outdoor exercise facilities and opportunities, cells and their equipment, health care and the provision of information on rights. The following contains a summary of the observations and recommendations made.

- Only a few police prisons have facilities for activities outside the cells. As a rule, the outdoor exercise yards at police prisons are small. Some of them are so enclosed and secure that there is no view outside and, for instance, tobacco smoke remains in the space for a long time. It is questionable whether being in such areas can be called outdoor recreation at all.

- Renovations are not considered unexpected exceptional circumstances that would justify limiting the right of persons deprived of their liberty to outdoor exercise (Imatra).

- Cells do not usually get natural light and do not often have TV and electrical sockets.

- A cell did not have a call button (Espoo).

↳ **The Deputy-Ombudsman recommended** that the police prison should avoid using the cell unless it can provide continuous monitoring.

- The cells for intoxicated persons did not have call buttons (Åland).

  Comment: *The Åland police has notified that it will install call buttons in the cells.*

- Renovated cells intended for remand prisoners did not have proper storage facilities for property (*e.g.* clothes) and food, and some of the property had to be kept on the floor. There was no place for hanging up clean laundry to dry in the cell, and no other place had been designated for the purpose (Vantaa).

↳ **The Deputy-Ombudsman recommended** that the police prison should consider adding storage solutions to the cells so that, for example, food items would not have to be stored on the floor. He also recommended that the police prison should arrange a space for drying clothes.

- The toilets of cells for remand prisoners did not have hand-held showers (Vantaa).

↳ **The Deputy-Ombudsman recommended** that police prisons should pay particular attention to female remand prisoners' need to maintain their personal hygiene and provide them with an opportunity to shower more frequently.

- In police prisons, remand prisoners are usually given bedlinen made of cloth.

  The Deputy-Ombudsman recommended that police prisons should ensure, on their own initiative, that the bedlinen used by remand prisoners are clean and undamaged and that they are changed when necessary.

- The confidentiality of phone calls with an attorney was not ensured in two police prisons, as the supervising warder was able to hear the remand prisoner's part of the conversation.

  Comment: *The police reported that practices have been changed after the visit.*

- The visits of an attorney may only be supervised if this is necessary or specifically requested by the attorney or the remand prisoner. As a rule, supervision cannot be considered necessary. The visit can take place in a room with a CCTV camera if the attorney and the remand prisoner can ensure that the camera is not on (Vantaa).

  The Deputy-Ombudsman recommended that any cameras in such visiting rooms should be covered and the attorney and the remand prisoner should be clearly told that the camera is not on.

- In previous years, attention has been paid to the fact that prisoners' toilet facilities were within the reach of CCTV cameras, meaning that there was no protection of privacy. The problem is exacerbated if the warder is of a different gender than the prisoner. The issue had still not been dealt with in two police prisons even though the National Police Board had already drawn the police departments' attention to the problem.

  Comment: *The police prisons resolved the issue after the visit.*

- It was observed during visits that warders were not familiar with the appeal provisions of the act on the treatment of persons in police custody (841/2006). The provisions apply, among other things, to decisions concerning the possession of property. The forms needed for the decision-making procedure and for making a claim for a revised decision were also not available. This was the case in the majority of police prisons visited.

  Comment: *The police have reported addressing the issue in their internal communications and ensuring the availability of the forms.*

- Police prisons did not have written information about the authorities that supervise police prisons to be provided to persons deprived of their liberty if they are unsatisfied with the way they have been treated or want to make a complaint for some other reason.

  The Deputy-Ombudsman considers it justified for police prisons to have written information about supervisory authorities.

- In two police prisons, it was noted that persons deprived of their liberty had not understood the information they had been given about their rights.

The Deputy-Ombudsman pointed out to the staff of the police prisons that persons deprived of their liberty must be informed of their rights in a comprehensible manner.

- Health care arrangements have room for improvement in all police prisons. Most police departments do not enjoy regular visits from health care staff. Instead, persons deprived of their liberty are taken to health centres when necessary.

- When persons deprived of their liberty arrive at the facility, they are not given a health examination and their health is not checked during the deprivation of liberty unless they request it.

The Deputy-Ombudsman has recommended that police prisons should try to ensure that all persons deprived of their liberty for longer than 24 hours get to see a health care professional.

The Deputy-Ombudsman has required that all persons deprived of their liberty be told upon arrival about their right to receive health care in the place of detention, at their own expense, with the permission of a doctor arranged by the police.

The Deputy-Ombudsman has emphasised that a detained person's need for treatment must always be assessed by a health care professional and not by, for example, a police investigator. This applies to all forms of health care, including oral health care.

- The practices of distributing and recording medication vary. Warders have received training in the distribution of medication only in exceptional cases, and medicines are not always stored appropriately.

The Deputy-Ombudsman recommended that the police prison should try to provide the health care professional working in the place of detention with appropriate facilities. At present, medicines were distributed in a room shared with the staff of the detention facility. As there was also no separate treatment room and patients were seen in their cells, the Deputy-Ombudsman recommended that all staff at the detention facility should pay special attention to ensuring the privacy of detained persons while they receive treatment and are being examined (Vantaa).

3.2 Defence forces detention facilities

In 2016, the NPM conducted two visits to the detention facilities of the Finnish Defence Forces. They were carried out unannounced in connection with the Ombudsman's regular visits to garrisons. The visits were targeted at the Kainuu Brigade and the Satakunta Air Command.

The treatment of persons deprived of their liberty in the detention facilities of the Defence Forces is subject to the provisions of the act on the treatment of persons in police custody (841/2006). During the visits, attention was paid to the structural elements of detention facilities in order to improve the safety of persons deprived of their liberty and to reduce the risk of self-harm.

- At the Kainuu Brigade, the closed space used for the detention of persons deprived of their liberty did not have a call button, an alarm device referred to in the act on the treatment of persons in police custody. The Deputy-Ombudsman noted that a communication method in which a person deprived of their liberty has to waive at a camera or knock on the door cannot be considered sufficient to ensure safety during detention. Such means do not always guarantee the attention of supervisory staff unlike a call button, which requires the control room staff to separately confirm receiving the alarm.

- At the Satakunta Air Command, the detention facility had a "curtain" that was made of a plastic bag or similar material and taped to the wall. The Deputy-Ombudsman considered it possible that self-destructive persons deprived of their liberty could use it to suffocate themselves.

The Deputy-Ombudsman recommended the immediate removal of the curtain. If the detention room cannot otherwise be darkened when a person deprived of their liberty so wishes, it should be considered whether the window could be covered in a similar manner from the outside.

3.3 Border guard detention facilities

Based on the information received by the Deputy-Ombudsman, the Finnish Border Guard currently uses 15 closed spaces for the detention of persons deprived of their liberty. They are used for short-term detention before transferring persons to a police prison, a detention unit or a reception centre. The duration of detention in these facilities varies from one hour to several hours. The maximum time is in all cases 12 hours.

The location, standards and equipment of the facilities vary. During the year under review, no visits were made to the facilities. However, the following describes the measures required as a result of the Deputy-Ombudsman's earlier visit to the detention facilities of the Border Guard.

The administrative units of the Border Guard have adopted rules for the Border Guard's detention facilities. In addition to the national languages, the rules will be translated into English and Russian as well as other languages depending on the largest nationality groups using a given border crossing point.

In 2014, the Deputy-Ombudsman conducted a visit to the joint detention facilities of the Border Guard and the Customs at the Vaalimaa border crossing point. She decided to launch a separate investigation on the conditions and treatment of persons held in the facilities by the two authorities. The Deputy-Ombudsman requested, in particular, information on the division of responsibilities in the use and supervision of the facilities, guidelines and the implementation of CCTV monitoring.

On closer examination, it turned out that the facilities had not been identified as facilities that are subject to the provisions of the act on the treatment of persons in police custody and would have to be approved by the Border Guard before persons deprived of their liberty could be held in them. Thus, the inspected detention facilities had not been approved for the purpose. It also turned out that the Border Guard did not have a single detention facility approved under the Border Guard Act.

In a decision adopted in 2015, the Deputy-Ombudsman required that all facilities under the Border Guard's administration that are used for holding persons deprived of their liberty have to approved in accordance with the procedure set out in the Border Guard Act and the rights guaranteed for persons deprived of their liberty in various acts must be taken into account in the approval process. In order to keep track of the total duration of deprivation of liberty, the Deputy-Ombudsman considered it important that the time when a person is placed in a detention facility is always appropriately recorded. Moreover, the conditions in the facilities must ensure treatment with human dignity as required by fundamental and human rights.

During the investigation, the Border Guard Headquarters began its own examination of the detention facilities and conditions of persons deprived of their liberty in all border guard districts. The examination also covered the requirements set for detention facilities and their approval procedure in more general terms.

Following the Deputy-Ombudsman's opinion issued to the Border Guard, the rules of the Vaalimaa detention facility, drawn up by the Customs, mention that closed spaces in the facility are equipped with an alarm device that enables immediate contact with the staff. According to information provided by the Border Guard, the alarm system is still missing from two older detention facilities. The issue had been resolved by an order from the Border Guard, one of the co-users of the facilities.

3.4 Customs detention facilities

No visits were made to the detention facilities of the Customs in 2016. The measures taken in connection with the 2014 visit concerning the detention facilities and monitoring arrangements at the Vaalimaa Customs are discussed above in the section on the Border Guard. The report provided by the Customs showed that it also had not identified the detention facilities as facilities that are subject to the provisions of the act on the treatment of persons in police custody and would have to be approved by the Customs in accordance with the Customs Act or would require rules.

The Deputy-Ombudsman issued a decision addressed to the Border Guard in 2015. In the decision, she considered it important that persons deprived of their liberty on the same grounds must be treated equally in all cases, regardless of which authority is in charge of the detention. The decision was sent to the Customs for information, after which the Customs drew up rules for the Vaalimaa detention facility in February 2016.

In a decision issued in May 2016 concerning the Customs, the Deputy-Ombudsman referred in connection with CCTV monitoring to the opinions of international monitoring bodies and the decisions of the overseer of legality. She drew particular attention to the need to ensure the protection of privacy in toilet facilities. The Deputy-Ombudsman also noted the importance of providing detained persons with sufficient information on the special conditions mentioned in the rules of the facility and other provisions that apply to them. A detained person must be in possession of or have access to the rules of the facility as laid down by law.

The Deputy-Ombudsman drew particular attention to the rules on the use of telephone. Under the act on the treatment of persons in police custody, it is prohibited to listen to phone calls between an attorney and his or her client. The conditions must guarantee the confidentiality of such telephone calls. According to the act on the treatment of persons in police custody, the rules of a facility shall include provisions on the use of telephone.

The Deputy-Ombudsman communicated her views to the Customs and required the Customs to assess the need to also draw up rules for the other facilities it uses.

In August 2016, the Customs notified that it had further specified the rules of the Vaalimaa detention facility with respect to the privacy, access to information, communication and telephone use of persons deprived of their liberty. According to the Customs, persons deprived of their liberty are provided with a copy of the rules, which have been translated into Swedish, Russian and English. The Customs also reported that it is considering the need to establish rules for its other detention facilities (in total 10). The Deputy-Ombudsman found nothing to criticise in the Vaalimaa rules after the clarifying amendments. In other respects, progress will be monitored.

The Deputy-Ombudsman has considered the concepts and contents of international legal and executive assistance in a matter in which a criminal investigator from another country had, with the permission of the head of the investigation at the Finnish Customs and in the presence of an investigator from the Customs, interviewed a complainant who was in remand imprisonment about the complainant's connections to other offences than the one being investigated in Finland. The Deputy-Ombudsman took the view that in the circumstances it was problematic to justify the procedure on the grounds of consent. The Deputy-Ombudsman informed the Customs that collaboration among pre-trial investigation authorities and customs authorities must be based on international agreements and acts and comply with the procedures laid down in them.

3.5 Criminal sanctions field

The Criminal Sanctions Agency operates under the Ministry of Justice and is responsible for the enforcement of sentences to imprisonment and community sanctions. The Criminal Sanctions Agency runs 26 prisons. Prisoners serve their sentences either in a closed prison or an open institution. Of Finnish prisons, 15 are closed and 11 open institutions. In addition, certain closed prisons also include open units. Visits focus mainly on closed prisons. The average number of prisoners in 2016 was approximately 3,100. In January 2016, the Health Care Unit of the Criminal Sanctions Agency was transferred to operate under the Ministry of Social Affairs and Health as the Prisoners' Health Care Unit.

In 2016, visits were conducted to 11 prisons, four of which were open institutions. The sites visited were Käyrä Prison, Turku Prison, Jokela Prison, Riihimäki Prison, Suomenlinna Prison, Ylitornio Prison, Oulu Prison, Kestilä Prison, Pelso Prison, Mikkeli Prison and Kylmäkoski Prison. The supervision patrol activities of the Criminal Sanctions Region of Southern Finland were also examined. Three of the visits were unannounced. An external expert participated in one of the visits (Kylmäkoski). Rather than covering the entire prison, some of the visits only focused on certain activities, units or groups of prisoners. For example, the visit to Jokela Prison focused particularly on the conditions of isolation cells and the so-called "travelling cells" for temporary accommodation and on the procedure used when placing a prisoner in isolation under observation.

Three visits were made to the Riihimäki Prison in 2015. The visit conducted during the year under review was a follow-up to the earlier visits. It focused on the problems identified during previous visits and in complaints as well as on the measures that the prison had taken in response. In addition to the prison management, a representative of the regional administration and the Director General of the Criminal Sanctions Agency were also invited to the final discussion during the visit.

Three visits were made to the Prisoners' Health Care Unit (outpatient clinics in Turku and Kylmäkoski and Prison hospital). The related observations are discussed in the section on health care.

Placement within a prison

- The following groups of prisoners had been placed in the isolation unit: remand prisoners subjected to segregation by court order, prisoners who had requested segregated accommodation and prisoners segregated for other reasons. (Turku)

The Deputy-Ombudsman pointed out that the isolation unit is not intended for accommodation and is inappropriate for the purpose.

- Remand prisoners had not been separated from convicted prisoners because the prison only had one unit for remand prisoners (Turku and Oulu). One prison did not have a single unit for remand prisoners even though they constituted approximately 40 per cent of all prisoners. (Mikkeli)

The Deputy-Ombudsman emphasised that remand prisoners and prisoners who are serving a sentence should be placed in different units.

Comment: *Mikkeli Prison reported later that it dedicated five units to remand prisoners.*

- A prison had two prisoners under the age of 18. One of them had been placed in a closed unit and the other in the same unit with adult prisoners. (Turku)

The Deputy-Ombudsman pointed out that minors should always be accommodated in separate facilities to which adult prisoners have no access. When activities are organised for minors outside their cells together with adult prisoners, supervision must be sufficient.

- In certain prisons, many units have been designated as substance-free units. To be accommodated in these units, prisoners must agree to give a urine sample whenever requested. In practice, this commitment is a prerequisite for being allowed to participate in an activity or live in an open unit. (Oulu and Pelso)

The Deputy-Ombudsman emphasised that prisoners who do not wish to commit to a substance-free life should also have the opportunity to participate in activities or be placed in an open unit.

- Remand prisoners subject to segregation restrictions had been living in the admissions (a unit for newly-arrived prisoners) unit. (Oulu)

  ↳ **The Deputy-Ombudsman pointed out** that the admissions unit is not suitable for accommodation.

- Prisoners were regularly placed in an isolation cell immediately after a suspected disciplinary infraction and held in segregation pending the disciplinary procedure. In most cases, the events were clear and there was little or no need for investigating the disciplinary infraction. (Mikkeli)

  ↳ **The Deputy-Ombudsman did not consider** it appropriate that prisoners are held in isolation cells merely for poor behaviour when they do not pose a concrete threat to order in the prison.

  Comment: *The prison has notified that isolation cells will only be used when there is an actual need for isolation.*

Prison facilities and the equipment in cells

- The women's unit had no hand-held shower heads or bidet showers – only ceiling-mounted shower heads – which made it considerably more difficult for them to maintain their personal hygiene (Turku).

  Comment: *The prison promised to implement the necessary changes at the latest in early 2017.*

- Accommodation cells had no night lights or reading lights (Mikkeli).

- There were not enough facilities for children's visits (Turku) or they were otherwise inappropriate for the purpose (Mikkeli).

- The outdoor exercise area had no rain shelters (Turku, Oulu and Mikkeli) or benches (Oulu and Mikkeli). The area was also too small considering the number of prisoners outside at the same time (Mikkeli).

  Comment: *Turku Prison noted that prisoners are provided with waterproof jackets if it rains.*

  Comment: *Mikkeli Prison promised to expand the outdoor exercise area and improve its equipment. Moreover, the outdoor exercise area for segregated prisoners will only be used for justified reasons and short periods of time.*

- The window frame in the cell intended for disciplinary solitary confinement was broken. This affected the temperature in the cell and made it draughty (Jokela).

  Comment: *The prison took action to fix the window frame. They promised to consider prohibiting the use of the cell if the repairs were not completed by the beginning of October.*

- A prison's ability to take in prisoners with mobility impairments seemed very problematic even though the prison should have a cell for persons with disabilities. (Riihimäki)

  ↳ **The Deputy-Ombudsman pointed out** that the situation must be remedied to ensure that prisoners with reduced mobility can enjoy their legal rights on an equal basis with other prisoners without being treated differently from others due to the impairment without an acceptable reason. Unless the prison in question takes corrective action, it should not state that it can take in prisoners with reduced mobility. The Criminal Sanctions Agency should be able to provide appropriate facilities and enforce the sentences of prisoners with mobility impairments in accordance with the law.

- Cell doors that open inwards constitute a safety risk (Oulu).

- The facilities at the admissions unit were untidy. (Oulu)

  ↳ **The Deputy-Ombudsman emphasised** that the prison has the ultimate responsibility for ensuring cleanliness even if the task of cleaning has been assigned to prisoners.

- An open institution did not have appropriate isolation facilities. It also lacked appropriate facilities for providing a urine sample, even though samples are collected frequently. The process of providing a sample could not be supervised discreetly (*e.g.* through a one-way mirror). Instead, the supervisor was next to the prisoner in the toilet (Kestilä).

- After renovation, a prison had no room dedicated solely for religious activities. (Mikkeli)

  ↳ **The Deputy-Ombudsman referred** to the preparatory documents of the Imprisonment Act, which state that if a prison does not have a church, it should have some other place suitable for practicing religion. This "other suitable place" means a separate peaceful space.

  Comment: *According to the prison, a space reserved for practicing religion can be separated with screens from the rest of the multipurpose room.*

- Isolation cells had no furniture, and the prisoner had to eat on the floor. The cleanliness of the isolation cells was not up to standard. There were faeces on the bars of one of the cells. The toilet -seats in all cells were covered with stains, and one cell was missing a drinking water tap (Mikkeli).

The Deputy-Ombudsman pointed out that the conditions in isolation cells were inappropriate for the enforcement of disciplinary solitary confinement or the segregation of a prisoner pending the investigation of a disciplinary infraction.

Comment: *The prison reported that the isolation cells had been thoroughly cleaned and will only be used when there is an actual need for isolation.*

- Suspicion of wide-spread use of prohibited substances had emerged in a prison. Therefore, weight plates had been temporarily removed from the gym to prevent the prisoners using substances from injuring themselves. The amount of free weights available in the outdoor exercise yard were also to be limited for the same reason. The family visit room was out of use at the time of the visit, because a drug detection dog had given an alert in the room. The prisoners' sauna was also out of use for the time being because prisoners had been moved to the sauna and the changing rooms during a special inspection that concerned the whole prison, and the rooms had been damaged and dirtied (Kylmäkoski).

Comment: *After the visit, the prison director reported that the prison had been able to lift some of the exceptional measures that were taken due to the safety situation and had an impact on the prisoners' conditions. Free weights had been made available at the gym up to a certain level of weight. The family visit room had been renovated and was intended to be taken in use in early 2017. The sauna renovation was also nearly finished.*

The Deputy-Ombudsman asked the prison to report on the measures taken due to the drug situation.

Protection of privacy

- **The Deputy-Ombudsman pointed out** that telephones intended for use by prisoners should be located so that telephone conversations in a normal voice cannot be overheard by others. (Turku and Pelso)

Comment: *Turku Prison has begun planning the construction of telephone booths.*

- At a prison admissions unit, both isolation cells had CCTV monitoring. (Turku)

↳ Attention was drawn to the fact that camera monitoring of prisoners' cells is only allowed in the circumstances specified by law. If the preconditions are not met, a prisoner placed in a cell equipped with a camera must be told that the camera is not in use. For example, the camera may be covered.

↳ **The Deputy-Ombudsman emphasised** that prisoners' toilet use should not be monitored by a camera even if the preconditions for camera monitoring are otherwise fulfilled. Isolation under observation is an exception to the rule, but even in such cases arrangements should be made to ensure at least limited privacy. Monitoring can take place, for example, through tinted glass or plexiglass that obscures visibility.

Comment: *The prison reported that prisoners placed in isolation cells are not monitored unless there are grounds for it and that CCTV cameras are located in a way that prevents intimate areas from being visible to the control room when prisoners use the toilet.*

- **The Deputy-Ombudsman pointed out** that prisoners' should be able to send confidential messages to the outpatient clinic. (Turku)

Comment: *Turku prison reported that the outpatient clinic had promised to order pre-printed envelopes addressed to the unit for prisoners to send their forms to the health care unit.*

- In another prison, the Deputy-Ombudsman considered it positive that units had been equipped with locked mail boxes through which prisoners could send messages to the outpatient clinic. (Kylmäkoski)

- **The Deputy-Ombudsman encouraged** a prison to take measures regarding urine sample collection facilities that do not have a one-way mirror between the supervisor and the person under supervision to make the situation easier and more comfortable for prisoners and staff alike. (Riihimäki)

- One prison had no signs about CCTV monitoring in the visiting rooms or outside the visitor building of an open institution. (Suomenlinna)

The Deputy-Ombudsman pointed out that people must be informed of the use of technical monitoring devices.

Comment: *The prison put up a notification of the monitoring. According to the prison, information had previously been provided orally.*

- Prisoners were not allowed to wear their own clothes during visits. Prisoners were also required to wear prisoners' outfits in work activities and outside the prison (*e.g.* hospital visits). (Mikkeli)

The Deputy-Ombudsman pointed out that the practice was not based on law. This also applies to the skirts worn by Roma prisoners (Oulu).

Comment: *Mikkeli Prison agreed to change its practices.*

Supervisory staff's participation in the distribution of medicines

- The office of a prison unit had a basket with medicines to be given to prisoners as needed. Warders do not have access to prisoners' health records, which also include information on their medication. (Kylmäkoski)

Prisoners can give the health care unit their written consent allowing the unit provide information on their medication to supervisory staff who distribute medicines. In the Deputy-Ombudsman's view this would be a good practice in terms of patient safety and the legal protection of the warder distributing medicines.

- During a visit to an outpatient clinic, concerns were expressed about the inconsistent practices of supervisory staff in recording the over-the-counter medicines and PRN (as-needed) medicines they give to prisoners. (Kylmäkoski)

  The Deputy-Ombudsman considered such records to be important for patient safety. **He pointed out** that it is the director's duty to supervise that warders record the medicines they have distributed regularly and in a consistent manner.

  Comment: *During the concluding discussion of the visit, the prison director said that they would take action to harmonise recording practices.*

Legal protection of prisoners

- During visits, it is repeatedly necessary to draw the prisons' attention to the availability of or need to update information on the provisions that apply to prisoners or the contact details of the authorities that supervise the prison. Prisoners may also lack awareness of the availability of information on the relevant provisions. (Turku, Riihimäki, Suomenlinna, Ylitornio, Oulu, Pelso and Mikkeli)

  Comment: *As a rule, prisons have reported that they will rectify the deficiencies and provide their staff with guidance on the issue.*

  Comment: *Turku Prison has promised to provide a guidebook for newly-arrived prisoners in connection with their arrival check and to clarify the information on where guidebooks and relevant legal regulations are available. It also promised to ensure that the control room and library of each unit will have copies of the Imprisonment Act and the Remand Imprisonment Act.*

- None of the inmates interviewed by the NPM had been provided with orientation training or guidance on the activities, schedules and other practices of the institution upon arrival. The staff had not informed any of them of their rights and duties. Interviews with foreign prisoners revealed that they had not been given oral information about the above-mentioned aspects of prison life or their own rights and duties (Mikkeli).

  Comment: *The prison reported that each prisoner will be provided with a guidebook for new prisoners when they arrive at the institution. The guide will be translated into as many languages as possible.*

- Prisoners were unable to apply for permission for a child's visit in advance. At the beginning of the visit, the supervising warder would select the prisoner who was allowed to meet his or her child in the visiting room. (Turku)

The Deputy-Ombudsman pointed out that prisoners should be able to apply for permission for such visits in advance. The prison, in turn, must examine the preconditions for the visit and issue a decision on the matter.

Comment: *According to the prison, the practice has been changed and prisoners are now able to apply for permission for visits in advance.*

- The number of prison leaves (permission of leave) granted to prisoners seemed low. According to prisoners, their sentence plans had not been updated. (Turku)

The Central Administration of the Criminal Sanctions Agency was enquired about the measures it will take regarding the observations.

- A prisoner serving a disciplinary punishment had been placed in an isolation cell. (Jokela)

Comment: *According to the prison, this was a mistake. Disciplinary solitary confinement is usually implemented in a cell reserved for the purpose.*

- The rules of prisons included provisions on matters that could not be regulated by prison rules. On the other hand, the rules did not include provisions on all the matters that they should (Ylitornio, Mikkeli and Oulu). Prison rules and the guide for new prisoners did not reflect the amendments to the Imprisonment Act. (Pelso)

- A prison had made changes to its rules. (Mikkeli)

The Deputy-Ombudsman pointed out that prisons are not allowed to amend or approve their own rules. Instead, they need to be approved by regional directors. Prison rules have no legal effect until they have been approved. The changes introduced by the prison had an impact on the treatment of prisoners. The Deputy-Ombudsman considered the use of unapproved rules a very serious matter. The application of the rules had to be ceased immediately.

Commnet: *The regional director approved new rules for the prison.*

- Meetings between prisoners and their attorneys were held in a room with CCTV monitory (Oulu, Mikkeli). the video was also recorded (Mikkeli).

The Deputy-Ombudsman pointed out that these meetings should in principle be unsupervised. This means that the visiting room cannot have CCTV monitoring and the prisoner and attorney should not be separated by a plexiglass. The room should also be such that conversations cannot be overheard by others (Oulu). The recording camera is forbidden by law under all circumstances (Mikkeli).

Comment: *Mikkeli Prison reported that they would equip the camera with curtains in order that the attorney at law could close the camera.*

- A remand prisoner had been given access to the pre-trial investigation documents only for one night after the unit had been closed. The documents had been taken away in the morning before the unit was opened. (Mikkeli)

The Deputy-Ombudsman emphasised that remand prisoners should be allowed to prepare for their trials and have access to pre-trial investigation documents.

Comment: *The prison reported that in the future all material required for a trial will be given to prisoners for the period they request, including daytime.*

- A prison did not issue administrative decisions on the possession of property, and prisoners were not given appeal instructions. It appeared that the prison had never issued any decisions on denying the possession of property as required by law. The prison director had given guidelines on the possession of property, which were used as a basis for decisions on access to property. One of the regional centres of the Criminal Sanctions Agency had nonetheless approved the practice in its response to a complaint. (Mikkeli)

The Deputy-Ombudsman pointed out that the director does not have the power to issue such guidelines, and decisions on denying the possession of property cannot be based on guidance given by the director.

Comment: *According to the prison, it has begun issuing decisions on matters concerning the possession of property and providing instructions on claims for revised decisions.*

- In the same prison (Mikkeli), reasoned written decisions were also not issued on a number of other matters which according to law require formal decisions. They involved, for example, a prisoner's request for segregated accommodation, withholding a postal item, placing a prisoner under observation and prohibitions to visit. Moreover, the rules of procedure did not specify who is responsible for several key groups of decisions, such as decisions on the possession of property.

The Deputy-Ombudsman noticed that the reasons given by the prison to justify its actions and decisions were not based on law. He came to conclusion that decision-makers were unfamiliar with the relevant legal regulations or ignored them.

- An admissions unit's actions in relation to granting access to property and responding to inquiry forms were inappropriate. The delays in accessing services were too long. Moreover, the Deputy-Ombudsman considered it a shortcoming that prisoners were not given guidance about the fact that they have the right to choose which items they want to keep in their possession, if the number of items in the cell has to be limited, for example, for fire safety reasons and that this rule was not taken into account. (Mikkeli)

Comment: *The prison reported that the tasks of the admissions unit have been reviewed. The maximum time of delivery is now one week.*

Contacts with the outside world and freedom of expression

- The new telephone system of all prisons has a feature that blocks call transfers; in other words, the call is cut off if it is transferred from the first dialled number to some other number. This has made it more difficult for prisoners to call, for instance, their solicitors and authorities or even prevented them from making such calls. (Turku)

The Deputy-Ombudsman urged the prison to ensure that facilities intended for this purpose in all units have enough hands-free headsets and that both prisoners and staff are aware of the opportunity to use them.

Comment: *The prison reported that from now on prisoners have access to headsets.*

- Certain prisons have adopted a policy of organising supervised visits during weekends only on one day. The number of visitors is often also limited, for example, to two adults and two children. (Oulu)

The Deputy-Ombudsman emphasised that visit arrangements should be such that they effectively ensure the implementation of a prisoner's right to visitors. If a visitor has a justified reason for not being able to visit the prison during the specified visiting hours, the prison should be open to the possibility of organising a visit at some other time.

Denying permissions of leave or applying limited visiting arrangements do not promote prisoners' reintegration into society by helping them maintain close relationships with others. With respect to family members, restrictions are also problematic in terms of the protection of family life. Closed prisons should organise an opportunity for supervised visits in a way that enables a prisoner's whole family to take part on a weekly basis.

- A prison's policy of granting permission for unsupervised visits was stricter than those applied by other prisons. Moreover, the times reserved for children's visits were on weekdays in the middle of the day. It was difficult for visitors to visit the prison during the reserved times (Mikkeli).

Comment:

The prison changed its visiting hours

The Deputy-Ombudsman still considered the visiting room inappropriate.

- Attention was drawn to the fact that a prison subscribed to a limited number of newspapers and had a small library collection. (Oulu)

The Deputy-Ombudsman pointed out that foreign prisoners should also have the opportunity to watch television and listen to radio in a language they can understand.

- After its renovation, the prison no longer had a library and loans from public libraries were not allowed. As a consequence of these observations made by the inspectors of the Criminal Sanctions Agency's Central Administration, the prison set up a library, which was located in a very small room which prisoners could not access one unit at a time. Library visits were also not included in the daily schedules of units. The library had a very limited book collection, and foreign-language literature was mainly available in Russian (Mikkeli).

  The Deputy-Ombudsman was of the view that the library service of a prison did not meet the requirements laid down by law.

  Comment: *According to the prison, prisoners now have access to the library one unit at a time once a week without prior registration.*

  The Deputy-Ombudsman recommended that the prison should consider moving the library to the multipurpose room, which seems to have no other use.

- **The Deputy-Ombudsman pointed out** that the mail send to prisoners should be delivered as soon as possible, not only 2 or 3 times a week. (Oulu)

Treatment, equal treatment

- All female prisoners did not have the opportunity to have a sauna (Oulu).
- Prisoners placed in the isolation unit did not have the opportunity to shower daily (Pelso).
- Answers to inquiry forms only included the initials of the replying staff member instead of his or her signature, name and title. Prisoners' questions were not always answered, and the language used was sometimes inappropriate (Mikkeli).

  Comment: *The prison emphasised the correct procedures and practices to its staff.*

- One prison applied a permission of leave policy that diverged from those of other prisons without a justifiable reason. Due to policy differences, prisoners are not treated equally with the inmates of other prisons when granting permissions of leave (Mikkeli).

  Comment: *According to the prison, special attention has since then been given to granting permissions of leave.*

- The Central Administration Unit of the Criminal Sanctions Agency has issued guidelines on imposing disciplinary punishments. The guidelines aim to harmonise the practices and policies of prisons. One prison applied a practice that was clearly stricter than the guidelines. Severe disciplinary punishments were imposed for minor infractions. As a rule, the prison imposed the maximum punishments defined in the guidelines or even more severe sanctions. Disciplinary decisions did not specify reasons for the application of maximum sanctions. In addition to the lack of justifications, decisions also included deficiencies concerning the recording and investigation of infractions (Mikkeli).

- The relations between the prison staff and prisoners were tense and poor. Prisoners expressed heavy criticism regarding the actions of the prison and its staff. They described the staff's behaviour as commanding, disdainful, arbitrary and humiliating. It also appeared that prisoners were often taken to the isolation unit using force even if the prisoners' behaviour did not warrant the use of force. It also seemed that in certain cases the staff had unnecessarily caused the situation to escalate with their own actions. The prison had many practices that were different from those followed in other prisons, were not based on law and were partially against provisions.

  In the interviews, prisoners mentioned, for example, that they had too much idle time. They considered it degrading that warders sometimes gave them their meals through the hatch in the cell door.

The Deputy-Ombudsman considered the practice of serving food through the hatch to be inappropriate. He noted that warders should supervise prisoners and their facilities. Serving food is a natural opportunity for doing that and also for assessing the prisoner's condition by talking to them.

The Deputy-Ombudsman considered that the polarisation between prisoners and staff was stronger than usual, and a certain atmosphere of fear prevailed between the two groups. He considered it highly important to change the prison's operating culture and attitude towards its inmates. The atmosphere would likely improve if the prison discontinued its unjustified and unlawful practices that were very different from those applied in other prisons (Mikkeli).

Comment: *The prison has reported that it will launch various projects concerning the treatment of prisoners and the relations between prisoners and staff in accordance with its action and development plan for 2017. It will introduce a feedback system for prisoners. Food will no longer be served through the cell door hatch.*

- Foreign prisoners were interviewed in Arabic, Sorani and Russian with the help of interpreters. They said that none of them were provided with information on prison rules and activities or their own rights and duties when they first arrived. The prison had not provided interpretation. Two of the prisoners had been urged to learn Finnish if they wanted to speak with the staff. One remand prisoner had requested access to interpretation for approximately a month in order to settle

and arrange personal matters. The requests had been unanswered or denied. Remand prisoners told that they had been unable to call their families to let them know that they were imprisoned in Finland (Mikkeli).

- Based on discussions with supervisory staff, the prison personnel had not been provided with training on dealing with prisoners who need special support. The flow of information between the supervisory and health care staff was also considered a problem due to confidential regulations.

↳ **The Deputy-Ombudsman noted** that attending to inmates with special needs is difficult, particularly because the supervisory staff have not received relevant training.

↳ **The Deputy-Ombudsman recommended** that the prison should actively contact the Prisoners' Health Care Unit whenever there is a need for guidance and training on these matters. Confidential regulations do not prevent the disclosure of information if the health care unit asks prisoners to give their written consent to the disclosure of their personal information (Kylmäkoski).

- The visit supported the view that the prison had succeeded in creating problem-free relations between Roma prisoners and prisoners from the majority population. This is not the case in many other prisons (Kylmäkoski).

Lack of time and activities outside the cell

Almost without exception, closed prisons contain units where the prisoners are forced to remain inactive in their cells the best part of the day without an acceptable reason stated in the law. Acceptable justifications for keeping a prisoner in isolation may include safety measures or isolation as a disciplinary sanction, which are relatively short-term situations. In the worst cases, isolation and inactivity mean that a prisoner is placed in a special unit for a lengthy period without justification. In addition to lack of activity, the problem in this case is that the unit is not intended for actual residential use, and the conditions in it are thus not suitable for long-term living.

On visits, attention is usually paid to the prisoners' possibilities of spending time outside their cells and participating in meaningful activities. Prisons have been informed of the fact that keeping prisoners inactive in their cells is unacceptable and unlawful. This problem mainly stems from lack of resources in prisons, rather than ignorance of the regulations or unwillingness to organise activities for the prisoners.

- When conducting an inspection in a prison, the Central Administration of the Criminal Sanctions Agency had drawn the prison's attention to the need to improve the operation of units with the strictest security by extending the hours during which the prisoners can leave their cells and developing and extending activities indicated by the prisoners' needs. As the Central Administration was planning a follow-up inspection of the prison in question, it was asked to report on the action taken (Mikkeli).

- A remand prisoner who could not speak Finnish had been kept isolated from other prisoners and without any activities outside the cell for months, excluding the possibility for outside exercise. The cell window was small and placed high up, only showing a view of the sky. The window was locked, making it impossible to air the cell. The prisoner had no meaningful pastimes in the cell, except watching television. According to information obtained by the NPM, the prisoner was illiterate and had no common language with the prison staff. The prisoner was also obviously in severe pain. (Oulu)

The Deputy-Ombudsman noticed that the prisoner's isolation was based on a court order and was thus not a breach of law. However, he found the space for outdoor exercise unsuitable for its purpose because of its small size, lack of exercise facilities and roof and closed-in walls. He considered the conditions of outdoor exercise and complete lack of exercise and activities outside the cell unacceptable.

The Deputy-Ombudsman was also concerned about the prisoner's state of psychological and physical health and the conditions in the cell. The prison management was informed. The prison and the prison outpatient clinic were asked to report on action taken.

Comment: *After the request for information was received, the prisoner was placed in the Psychiatric Hospital for Prisoners for a three-week treatment period. The prison reported that since that time, the prisoner's physical and psychological state had clearly improved.*

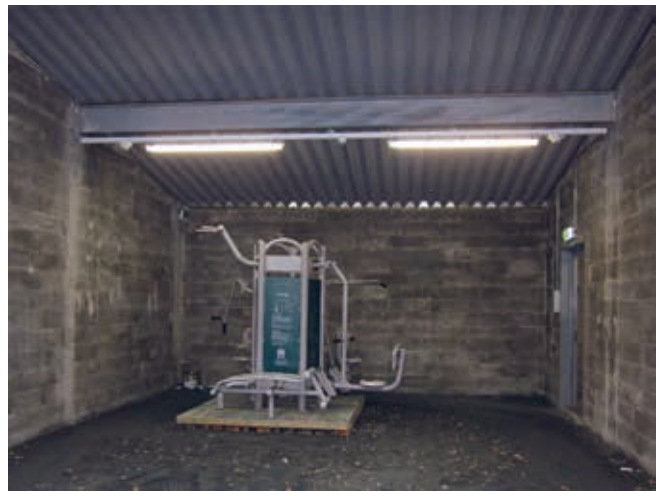
- The prisoners' possibilities of taking exercise were inadequate. (Turku)

The Deputy-Ombudsman recommended organising gym training led by an instructor.

- In another prison, there was no gym, and the prisoners only had access to a sports hall for 30 minutes once a week (Mikkeli).

Comment:

Mikkeli Prison promised to improve the prisoners' possibilities of taking exercise by striving to use the sports hall more often and by purchasing exercise equipment for the common areas of the cell units. According to the Deputy-Ombudsman, the prison should continue investigating options for setting up a gym.



Basic education

For several reasons, the arrangements for organising basic education in a prison were unsatisfactory. Forming teaching groups was challenging, and the use of distance teaching by a video link had not gone ahead in the prison, either. (Kylmäkoski)

The Deputy-Ombudsman made reference to remote general upper secondary school studies based on video links organised in prisons of the Criminal Sanctions Region of Eastern and Northern Finland. His assessment of the situation was that teaching could also be organised following the same operating model in the Criminal Sanctions Region of Western Finland.

The Deputy-Ombudsman asked the prison to report on actions taken to arrange basic education for prisoners.

Supervision patrol activities

In addition to prisons, the activities of the criminal sanctions authorities that supervise sentences served outside prison were investigated on visits. On certain conditions, a prisoner may be placed outside the prison for a trial period and supervised by means of technical equipment and other methods before conditional release (parole). Some short prison terms may be converted into monitoring sentence outside the prison. Persons sentenced to this type of a penalty may only move within a specified area outside their homes.

Their movements are supervised by technical methods. The criminal sanctions authorities supervise the serving of both types of penalties by means of unannounced inspection visits to homes, workplaces or other areas where these persons spend time. This supervision is performed by so-called support patrols. Support patrol activities were scrutinised in the Criminal Sanctions Region of Southern Finland. The observations made during the visit were related to the organisation of the activities and occupational safety.

3.6 Alien affairs

Slightly less than 5,700 asylum seekers made their way to Finland in 2016. The year before, this figure was some 32,000. Some 28,200 asylum decisions were made, in 51% of which asylum was denied. Under section 121 of the Aliens Act, an asylum seeker may be held in detention for such reasons as establishing his or her identity or enforcing a decision to remove him or her from the country.

The outdoor exercise yard at the detention unit of the Metsälä reception centre operated by the City of Helsinki.

There are two detention units for foreign nationals in Finland. Joutseno detention unit has 30 places, 10 of which are reserved for families, while Metsälä Unit has 40 places. As a result of the high number of negative asylum decisions, the number of foreign nationals taken into custody may be expected to increase. The Finnish Immigration Service has responded to this need, and according to its report, 40 new places will be set up in Joutseno detention unit in 2017. This must be considered a positive development, as otherwise there would be pressures to hold foreign nationals in the detention facilities of the police, which are only suitable for very short-term detention.

Some of the residents in reception centres and detention units may be victims of human trafficking, and recognising them is a challenge. The system of assistance for victims of human trafficking operates in connection with Joutseno reception centre. A press release from the Finnish Immigration Service relates that in 2016, the system of assistance received almost 2.5 times as many applications as the year before. Of the 130 new customers accepted to the system of assistance, 21 were minors. The year before, 52 new customers were accepted, all of whom were of age.

The NPM's target is to visit both detention units roughly once a year. The NPM visited Joutseno detention unit in 2015 and Metsälä unit in 2016. The visits were pre-announced in order to ensure that interpretors were available for the language groups of the persons held in custody at the time of the visit. The NPM interviewed several Russian, Arabic and Chinese speaking detainees with the assistance of interpreters.

- At the time of the previous visit in 2014 the Ombudsman had recommended that, when necessary, Metsälä detention unit should carry out a routine check-up on foreign nationals who have been returned to the detention unit after a failed attempt to remove them from the country.

  Comment: *On the most recent visit, the unit reported that after each failed attempt at removal from the country, the foreign national returned to the unit is offered a possibility of meeting a public health nurse.*

- A check-up is not automatically conducted on all persons taken into custody as they arrive in Metsälä unit. Instead, the person fills in an initial health interview form, on the basis of which his or her health care needs are assessed.

- However, the conclusions addressed to Finland by different international bodies have suggested that a routine medical screening should be carried out on persons deprived of their liberty within 24 hours of their arrival.

This had also been the Ombudsman's recommendation in connection with the actions taken as a result of the visit at Joutseno detention unit in 2015. At the same time, any experiences of torture and injuries of persons deprived of their liberty can be examined. The Ombudsman also stressed the necessity of routine check-ups in Metsälä unit.

- On the visit to Metsälä detention unit, it also transpired that the health care services do not visit foreign nationals placed in isolation on a daily basis.

The Ombudsman recommended that a person placed in isolation be visited as soon as possible after their isolation, and subsequently every day or even more frequently if necessary.

- Persons held in custody who were interviewed during the visit praised the unit's staff and felt that they acted properly. Not a single interviewee reported having experienced inappropriate behaviour or treatment at the detention centre. Observations made during the visit indicated that the staff treat the customers appropriately and respectfully and respond to their needs.

- However, it turned out during the visit that many of those held in custody were uncertain about their legal position and lacked legal advice. The customers' uncertainty about their position also emerged in interviews conducted with the staff.

- On his visit to Joutseno detention unit, **the Ombudsman had expressed** his view that the instructions related to hunger strikes followed in the unit were not suitable for situations where, for example, the customers initiated a mass hunger strike.

  Comment: *Since then, in June 2016, the Finnish Immigration Service issued instructions for situations where a person seeking international protection or taken into custody or a victim of human trafficking goes on a hunger strike. These instructions also address the possibility of a hunger strike involving a group of people.*

- In the reporting year, the Ombudsman also visited five different reception centres and six group homes or assisted living units intended for unaccompanied minor asylum seekers. These sites were not regarded as falling within the NPM's mandate as they do not restrict the residents' freedom of movement or use other restrictive measures. This situation may change, however, as regulations on residence requirements and new protection measures related to residence requirements applicable to children have been included in the Aliens Act. For example, a child may be ordered to remain within the area of a reception centre in the future. These amendments will enter into force in 2017.

The Ombudsman also does not supervise the return flights of foreign nationals in his role as the NPM, even if he has the competence to do so. The reason for this is that the Non-Discrimination Ombudsman has been assigned the special task of monitoring removals from the country.

3.7 Social welfare / Children's units

Three child welfare units were visited in 2016: Pienkoti Aura (Jyväskylä), Nuorisokoti Hovila (Jyväskylä) and Veikkari special children's home (Paimio).

Visits to child welfare units are usually unannounced. As an exception, the visit to Veikkari special children's home was pre-announced to ensure that as many of the children placed in this unit as possible would be present and could be heard.

There was a special focus during the reporting year on the conditions and treatment of unaccompanied minor asylum seekers at reception centres. Visits were conducted on six different sites in total: Karhusaari group home (Helsinki Deaconess Institute), Turku Reception Centre's group home (Finnish Red Cross), Heikkilä assisted living unit (Medivida Oy), Siuntio assisted living unit (Finnish Red Cross), Keuruu assisted living unit (Finnish Red Cross) and Säynätsalo assisted living unit (Jyväskylä region support home). The visits to reception centres were also unannounced.

The purpose of the visits was to gather information on the well-being of the young people placed in these units, their living conditions and the organisation of reception services. It was also verified that every child had a guardian, that legal aid had been organised for them and that they knew how to contact their guardians and counsels. The minors in these units are not subjected to restrictive measures and, for example, their freedom of movement may not be restricted under the law. Consequently, the visits were conducted under the Parliamentary Ombudsman's mandate rather than in the Ombudsman's role as the NPM.

Pienkoti Aura

- The NPM welcomed the unit's efforts to provide for and promote the children's right to meet and keep in touch with their parents and other significant persons. Meetings between children and their family members were supported systematically: for example, the unit paid for the children's and their family members' travel costs to the meetings. Family members could also stay overnight in the visitors' room at the unit. Additionally, the unit had a flat in the centre of Jyväskylä where children and their family members could spend weekends together.

- The unit has a practice of recording meetings between a child and a social worker and the way the meetings carried out.

The Deputy-Ombudsman concidered that this is a good practice and promotes the realisation of the child's rights.

- The staff were unsure of how requests for access to a document should be processed. The unit received general guidance related to correct practices during the visit. When a child leaves substitute care, the daily notes made on the child in the unit are usually destroyed by order of the municipality that placed the child in care, rather than filed in the municipal archive.

- As a spot check, one decision to restrict a child's freedom of movement was analysed. Shortcomings were found in it: the section on hearing the interested parties did not relate the content of the hearings or the views expressed. The manner in which the interested parties were informed of the decision, the date of the decision, or the party issuing the decision had not been recorded in the decision. The instructions for appealing the decision were also incorrect.

The unit was provided with guidance related to correct procedures.

Nuorisokoti Hovila

- The institution has a practice of recording meetings between a child and a social worker and the way the meetings are carried out.

The Deputy-Ombudsman concidered that this was found a good practice and promotes the realisation of the child's rights.

- The seclusion room did not have a call button, and a child placed in it had to draw the staff's attention by knocking on the door or the wall.

The Deputy-Ombudsman's view was that an isolation room should have an alarm system.

Comment: *The Deputy-Ombudsman was informed during the visit that an alarm system is about to be installed in the isolation room as part of the youth home's new call system. The new system will make it possible to install an alarm device both in the isolation room and in each young person's room.*

- When children arrive in the unit, they are asked to strip, and a decision on a physical examination is made on this procedure. As this practice was discussed with the home, it was noted that asking a child to strip is a bodily search, not a physical examination referred to in the Child Welfare Act. On the other hand, the Child Welfare Act provision on bodily search does not give a right to strip the child.

The Deputy-Ombudsman proposed to the Ministry of Social Affairs and Health that the Ministry assess whether the provision on bodily search should be reviewed, at least in the case of young people who are the most demanding to care for.

- Recording CCTV system was installed at the unit's entrances. The unit's staff or the children placed in the unit were not aware of being recorded, even if a notice stating this was attached to the building's door.

The Deputy-Ombudsman noted that the residents and employees of the unit, and possibly also outsiders, should be adequately informed of the recording CCTV system.

Comment: *The unit's director reported that, in order to increase awareness, the issue would be discussed at future meetings with employees and customers.*

- The children could only use their phones during a limited call time. If their phone calls are restricted during this period, a decision on restricting contact is made.

The Deputy-Ombudsman noted that if a child's right to use a telephone to keep in touch is restricted for reasons other than those related to their upbringing, a decision on restricting contact should be made, at least if this is demanded by the interested party.

- **The Deputy-Ombudsman pointed out** that a decision to restrict a child's freedom of movement or a decision on special care may not be used to also restrict a child's contacts. A separate decision that can be appealed should be made on restricting contacts.

- **The Deputy-Ombudsman launched an own-initiative investigation** of how a child's basic education is organised when he or she is subjected to restrictive measures.

Veikkari special children's home

- The difficulties young people experienced in accessing acute psychiatric care was found a problem in the unit. Even when a young person is taken by ambulance to a psychiatric assessment, he or she is usually returned to the unit the next day.
- The facilities were not accessible.
- Most social workers meet the children assigned to them at least twice a year, also outside meetings organised to prepare customer plans, which was considered positive. The social workers of a certain municipality, on the other hand, hardly ever come and meet the children placed in the institution by that municipality.
- As a rule, decisions to restrict a child's freedom of movement were made for seven days.

The Deputy-Ombudsman noted that when making decisions on the duration of such a restriction, the type of restrictions that are essential for the child's situation and interests in each individual case should be assessed. For example, routinely restricting a child's freedom of movement for at least seven days without individual grounds could not be considered acceptable.

- The unit had made a decision on restrictive measures that involved isolation concerning a young person who was registered with the unit but who, at the time the decision was made, was physically located at an other unit. The young person had been apprehended after running away and taken to another unit to wait for transport back to their place of substitute care. The unit had been following instructions issued to it.

The Deputy-Ombudsman found that the unit or the staff in the place of substitute care do basically not have a right to impose restrictive measures on a child outside the unit. Decisions on such measures should be made by the competent employee in the temporary place of substitute care.

- The unit had rules on using telephones and restricting telephone use in different situations.

The Deputy-Ombudsman stated that restrictions related to children's upbringing may never interfere with a child's statutory rights. For example, when children's use of personal phones is only restricted during the night with the intention of making sure that they get enough sleep, this is a normal rule related to their upbringing. If a child welfare institution restricts a young person's mobile phone use with a blanket ban, or if the young person's calls are listened to when he or she is using the institution's mobile phone, these are actual restrictions of contacts, on which a decision must be made.

- Based on the unit's practices, it appeared that the children are regularly searched when returning from leave or after having run off.

According to the Deputy-Ombudsman, these practices mainly seem to be based on the institution's own rules rather than individual consideration referred to in the Child Welfare Act. The Deputy-Ombudsman stressed that if a child is subjected to restrictive measures, there must be individual grounds for their use stated in the law. The measures must be justified in the relevant decision or in records kept on the measures. In principle, a child can give his or her consent to the search. The preconditions for this include explaining to the child that submitting to the search is voluntary. However, there should be no negative consequences for a child who refuses to consent to a search or testing. It appeared that, in practice, the children had no other option except to give their consent.

- The unit used a so-called grade system in which the young people progress as indicated by their behaviour and can attain different benefits and rights. They have the possibility of earning "Veikkari money" which they can use to buy the things they want.

The Deputy-Ombudsman found that the grade system used by the unit contains practices which have a bearing on the young people's fundamental rights and which may be used to factually restrict their rights and freedoms referred to in the Child Welfare Act without making a decision required under the Child Welfare Act.

The Deputy-Ombudsman decided to launch an own-initiative investigation on how the municipalities placing young people in the unit have supervised the grade system used by it and assessed its actual nature.

3.8 Social welfare / Units for older people

The Ombudsman conducts visits to care and residential units for older people in his role as both the NPM and the Parliamentary Ombudsman. When restrictions are placed on older persons in such units, the NPM is competent to pay supervisory visits to them. In many cases, the resident have memory disorders and their freedom of movement is restricted for this reason. The following four sites were visited in 2016: Palvelukeskus Hopeahovi (Kerava), Esperi Hoivakoti (Kerava), Harjukoti (Loppi) and Hoivakoti Salmela (Loppi). All these visits were unannounced.

On visits to units for older people, special attention is paid to whether the care and attention received by the residents is respectful of human dignity. Another key theme is how well the municipalities look after the right of their most vulnerable residents to the indispensable subsistence and care necessary for a life of dignity and adequate social and health services enshrined in section 19 of the Constitution.

The health care received by older persons and their access to physiotherapy/rehabilitation, oral hygiene and health, nutrition and hydration, personal hygiene and outdoor exercise/recreation are assessed on the visits. The staffing of the unit and the appropriateness of its facilities are also scrutinised. In addition, the NPM always look at how the residents' right to self-determination and privacy are implemented, what restrictive measures are used, and what decisions are made and records kept on their use.

- Based on observations made on the sites, regularly visits to the units by a doctor were considered a positive aspect in general.

- **The Deputy-Ombudsman concidered** as a shortcoming the lack of sufficient individual physiotherapy arranged for the residents.

- **The Deputy-Ombudsman found** the lack of outdoor exercise a problem on all sites – especially in winter and in the case of those residents who would like to go outdoors and who would benefit from it.

- Terminal care was as a rule provided appropriately. Apart from one unit, the staff had received or were about to receive training on terminal care.

- One unit provided terminal care in double rooms.

  The Deputy-Ombudsman found problematic in terms of the older persons' privacy and respectful treatment.

- In two units, all rooms were single rooms with private sanitary facilities.

- One unit additionally had small rooms of no more than 19 square metres intended for two residents, while another had rooms for up to four residents with no en-suite toilet. A curtain hanging from the ceiling could be pulled around the beds to provide privacy during care procedures.

  The Deputy-Ombudsman did not find these facilities compliant with modern requirements.

- In one institution, renovation work on the ventilation system was being carried out during the visit. A noisy machine was operated in the common area while three residents were spending time in it. No staff could be seen in this area.

  The Deputy-Ombudsman requested that the residents be moved to a more peaceful environment for the time of the renovations.

- The NPM familiarised themselves with the care plans of two residents in the unit and found them to be of poor quality.

  The Deputy-Ombudsman drew the unit's attention to the importance of care plans in safeguarding methodical care of a high quality and the need to prepare the plans meticulously.

  In another unit, **the Deputy-Ombudsman paid attention** to the fact that the care plans did not include providing oral healthcare or keeping records of it.

- The Deputy-Ombudsman drew attention to using diapers of the correct size. This is important in order to provide high-quality care and to avoid skin sores and other problems.

- The unit had a self-monitoring plan posted on the office wall.

  On request of the NPM, the unit promised to move the plan to the corridor for everyone to see.

3.9 Residential units for persons with intellectual and other disabilities

In total, nine residential units for persons with intellectual and other disabilities were visited. Three of these visits were unannounced. The units were located in Tampere, Ulvila, Kouvola, Helsinki, Kuopio and Kajaani and included both institutional care and housing services units. Of these, six were units for persons with intellectual disabilities, one a unit for persons with severe disabilities, and one a unit that cared for both types of customers. A doctor specialised in intellectual disabilities participated in one of the visits as an external expert.

Particular attention on visits to units providing institutional care and housing services for persons with disabilities was paid to practices related to restrictions of fundamental rights and the use of restrictive measures. On these visits, the Ombudsman stressed the importance of the new provisions of the act on intellectual disabilities (*laki kehitysvammaisten erityishuollosta, 519/1977*) that entered into force on 10 June 2016, using restrictive and protective measures as the last resort, and the significance of supporting the residents' right to self-determination when providing housing and rehabilitation services for persons with disabilities. The housing conditions, accessibility of facilities, possibilities for participation available for persons with disabilities and access to adequate assistance were also assessed on the visits.

With the ratification of the UN Convention on the Rights of Persons with Disabilities, the Parliamentary Ombudsman became part of the mechanism referred to in Article 33(2) of the Convention designated to promote, protect and monitor the implementation of the rights of persons with disabilities. The Ombudsman thus also paid attention to the implementation of the rights specified in the Convention on his visits.

- A visit was conducted in a unit providing institutional care for persons with intellectual disabilities (Antinkartano rehabilitation centre, Ulvila), partly because the Ombudsman had received complaints concerning the organisation of special care and the use of restrictive measures.

  ↳ On the visit, the staff's attention was drawn to the fact that so-called care-related measures (including support belts, helmets, bed rails) can in some situations restrict a person's fundamental rights and right to self-determination.

  ↳ The NPM brought up the new provisions on restrictive measures in the act on intellectual disabilities that must be taken into consideration when updating the instructions on using coercion. A decision must be made on the use of restrictive measures. Under the new provisions, the resident's legal representative, family member or similar also need to be informed of the decision without delay when the resident is personally unable to use legal remedies.

It was also pointed out to the staff that holding on to a customer for a short while, or for less than 15 minutes, in order to calm him or her down is also a restrictive measure.

- Corrective action had been taken by the social welfare services of Satakunta Hospital District as a consequence of the amendments to the act on intellectual disabilities that entered into force on 10 June 2016. Training related to the contents of this legislation had been provided for the staff, and new written operating instructions had been issued. The documents related to decisions on restrictive measures and instructions for appealing had been updated. Supervision within the hospital district's operating area has been intensified to ensure compliance with the new legislation.

- In a unit providing housing services for persons with intellectual and severe disabilities (Maununnitty, Kouvola) and an institutional care unit for persons with intellectual disabilities (Tuulikello, Kouvola), records kept on restrictive measures were very limited. Both commonly locked residents up in their rooms for the night (for up to 12 hours) as a restrictive measure. No separate decision that could be appealed had been made on locking the doors.

  During the visit, it was pointed out to the staff in both units that the residents' legal protection may be compromised by inadequate records and lack of decisions.

- Two wards of a unit providing institutional care for persons with intellectual disabilities (Kuusanmäki, Kajaani) had not, as late as in December 2016, started applying the amended provisions of the act on intellectual disabilities that entered into force in June 2016, and no decisions on restrictive measures had been made in the wards. For this reason, the residents lacked the possibility referred to in section 21 of the Constitution to have their cases dealt with appropriately by a legally competent court of law.

  The Ombudsman decided to investigate this matter separately on his own initiative.

- In acute situations, residents in a housing unit for persons with severe disabilities (Maununniitty, Kouvola) could only obtain assistance by shouting.

  The Ombudsman pointed out that the residents should always be able to contact the staff also by other methods.

- In a unit providing institutional care for persons with intellectual disabilities (Tuulikello, Kouvola) not all residents had the possibility of using the toilet at night. In this old property, the rooms did not have en-suite toilets, and a portable toilet was used instead.

  The Ombudsman stressed that the possibility of residents, also those with challenging behaviours, to use the toilet at night and to easily contact the night staff must be safeguarded.

- A unit providing institutional care for persons with intellectual disabilities (Tuulikello, Kouvola) had two secure rooms, one of which was in use at the time of the visit. The room had no furniture and no clock. The NPM were left unsure of how easily a person placed in the secure room could contact the staff. One entry in the records kept on restrictive measures noted that the person in question had urinated into a floor sewer.

  The Ombudsman drew attention to treating customers with dignity and good social welfare and health care. Persons placed in seclusion must have free access to a toilet. For this reason, too, a secluded person must have the possibility of contacting the staff without delay.

  During the visit the NPM discussed the possibility of placing clocks in the secure rooms, or in a place where the persons in the secure rooms can see them, allowing them to keep track of time.

  Comment: *After the visit, the service manager reported that the secure rooms had been equipped with clocks.*

- In a unit providing institutional care for persons with intellectual disabilities (Tuulikello, Kouvola), a customer lived in what was previously the secure room, as a result of soiling the rooms with faeces. The room was monitored by recording CCTV system.

  The necessity for camera surveillance was discussed during the visit. **The NPM pointed out** that it should only be used when this is absolutely essential in order to protect the resident's safety.

  The NPM also pointed out that the file description required under the Personal Data Act must be prepared when using a recording CCTV system.

  The NPM concidered that the room appeared very ascetic to be used for permanent residence. On a positive note, the resident also had access to other facilities in the immediate vicinity of the room.

  Comment: *After the visit, the service manager reported that the camera's recording capability had been disabled.*

- In a unit providing institutional care for persons with intellectual disabilities (Kuusanmäki, Kajaani), metal rings were found on the wall of the common area. A hammock had been attached to them that was no longer used.

The Ombudsman recommended that the metal rings be removed to eliminate a potential safety risk.

Comment: *After the visit, the service manager reported that the rings for the hammock had been removed.*

- An external expert that participated in a visit to a unit providing institutional care for persons with intellectual disabilities (Kuusanmäki, Kajaani) drew attention to the many drugs administered to one of the residents. The dose of one psychosis drug also exceeded the recommended maximum dosage.

The Ombudsman recommended that the customer's medication be reviewed.

- In a unit providing institutional care for persons with intellectual disabilities (Kuusanmäki, Kajaani), the residents were allowed to call their family and friends on two days a week using the ward's mobile phone. Only one customer had a personal mobile phone. The ward's phone could only be used in the presence of an instructor. Its use was restricted as any emergency and other calls were directed to the phone in question. Discussions with residents' family and friends and complaints received by the Ombudsman indicated that the residents found keeping in touch difficult.

The Ombudsman recommended that the ward review its practices in order to appropriately safeguard the customers' right to keep in touch with family and friends. He asked the unit to consider if the ward could have several phones, making it easier for the customers to contact their families.

- In a unit providing institutional care for persons with intellectual disabilities (Antinkartanon kuntoutuskeskus, Ulvila) problems were observed in the arrangements for the school attendance of customers in the age of compulsory education during institutional rehabilitation periods. After a visit in May, the rehabilitation centre managed to reach an agreement with the relevant municipalities on making appropriate arrangements for the children's school attendance, starting from the following autumn.

The Ombudsman requested that the social welfare services of the hospital district report on the situation at the end of 2016.

Comment: *According to information provided by the social welfare services of Satakunta Hospital District, some progress has been made with organising school attendance, but mainly due to the challenges presented by certain pupils, the issue has not yet been resolved in all respects.*

In addition, the NPM visited the psychological rehabilitation unit of Tampere University Hospital's Intellectual Disability Support Services in 2016. This was the only unit visited which, at the time of the visit, had customers in involuntary special care. This visit was follow-up on the first visit in November 2015. This time, the theme of the visit was hearing the customers and their family and friends. For this reason, the visit was pre-announced, and the unit was asked to inform the residents' family members and friends of it.

On the previous visit, it had been observed that the doors to some residents' rooms were kept lock at night, and the residents had no bell for calling the staff if necessary.

Comment: *The NPM were now informed that this practice had been dropped, and the doors of all residents are currently kept open, also at night. This was made possible by increasing the number of night staff.*

- The decisions on restrictive measures that the unit submitted in advance showed that in the case of one customer, so-called hygiene overalls had been used as a restrictive measure. When asked about the grounds for using the overalls, it turned out that the customer had kept stripping off and caused water damage with the discarded clothes. However, the latter reason had not been recorded in the decision.

In this context, the staff was instructed to record all grounds for using restrictive measures in the decision.

3.10 Health care

In the health care sector, the accurate number of those health care units that fall within the NPM's mandate is not available. A request for information has been submitted to the Ministry of Social Affairs and Health by the Office of the Parliamentary Ombudsman. The Ministry has been requested to submit to the Ombudsman a list of 1) units providing psychiatric special care, 2) secure rooms in the operating units of somatic health care, and 3) other health care operating units where people deprived of their liberty are or may be held. The processing of this request for information has not yet been completed at the Office of the Parliamentary Ombudsman.

Old medicine bottles in the Pitkäniemi Hospital Museum.

In early 2016, the media spread news of serious abuses uncovered in the closed psychiatric wards of Turku City Hospital. According to the newspaper report, patients had been humiliated, assaulted and drugged senseless. In February, the National Supervisory Authority for Welfare and Health (Valvira) initiated an own-initiative investigation to verify if Kupittaa Psychiatric Hospital was operating appropriately. It soon turned out that the incidents aired in public mainly had taken place in a single geriatric psychiatry ward at City of Turku's Kupittaa Psychiatric Hospital in 2013. Valvira together with AVI Southwestern Finland conducted two inspections in this ward. The second inspection also extended to other wards.

The Ombudsman monitored the investigation, and the decision issued by Valvira on 15 June 2016 and the inspection reports were forwarded to him. In its decision, Valvira noted that placing acute psychiatric patients in single rooms reduced the incidence of violence and the need for coercive measures, as well as accelerating patients' recovery. The general objective should be placing these patients in single rooms.

As a consequence of this incident, the Ombudsman felt there was a particular need to focus on geriatric psychiatry wards on visits to operating units of the health care system. While a geriatric psychiatry unit might not provide involuntary treatment referred to in the Mental Health Act it may, for example, find it necessary to restrict a patient's freedom of movement in a manner that falls within the NPM's mandate.

In the spring, the NPM visited the neuropsychiatry and geriatric psychiatry wards of the City of Tampere's Hatanpää Hospital and Pirkanmaa Hospital District's Pitkäniemi Hospital. A consultant psychiatrist participated in these visits as an external expert. Hearing patients with memory disorders is challenging, and it is usually not possible to obtain sufficient information on such questions as the patients' treatment this way. Consequently, the visits were pre-announced; the units were asked to inform the patients' family and friends of the visit and this opportunity to come and discuss their experiences of their family members' treatment and care with the NPM.

In both units, **the Ombudsman stressed** the hospital management's responsibility for preventing poor treatment of the patients.

The Ombudsman also recommended that the patients and their families be provided with more written information on patient rights and care plans.

Hatanpää Hospital

In Hatanpää Hospital, attention was paid during the visit to how the wards have provided for the safe mobility of patients with memory disorders.

The Ombudsman recommended that hand rails be fixed to the walls and that the flooring on one of the wards be repaired.

The use of different techniques for improving the patients' orientation was also recommended. For example, the patients' ability to find their own rooms and the common areas of the wards can be promoted by painting the doors in different colours or attaching pictures to them. The patients can be assisted in finding their own beds by means of identifying signs or personal items.

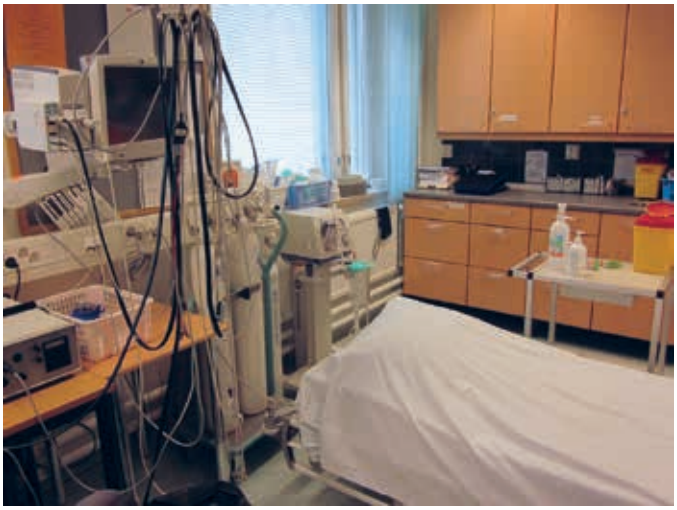
The Ombudsman also recommended that the doors of exercise yards and balconies be marked clearly to indicate when they are open.

The Ombudsman emphasised that the goal should be allowing the patients access to outdoor exercise on a daily basis if they so wish. A determined effort should be made to achieve this goal, if necessary by hiring more staff. The actual realisation of outdoor access should also be monitored, for example by a list drawn up for each patient.

- Shortcomings were found in instructions provided for security personnel.

The Ombudsman recommended that a point be included in the instructions stating that when safeguarding the personal integrity of staff members, the security guard must follow instructions provided by the staff.

The Ombudsman also recommended removing from the instructions references to legislation that only applies to patients placed under observation or in treatment by an order. The hospital did not treat patients involuntarily, and these provisions were thus not applicable.



An electroconvulsive therapy room in Pitkäniemi Hospital (visit on 20 April 2016).

Following the visit, **the Ombudsman launched an own-initiative investigation** of the following matters:

- The Ministry of Social Affairs and Health was asked to clarify and issue a statement on how the consent of a patient's legal representative to an important decision on treatment required under the Act on the Status and Rights of Patients can be obtained when the patient is unable to make the decision personally and has no family members or friends who participate in his or her treatment.
- The Regional State Administrative Agency was asked to establish and issue a statement on whether restraining a patient over long periods had been appropriate.
- Hatanpää Hospital was asked to establish how the contusions found in a patient's arm had been caused.
- Hatanpää Hospital was requested to provide information on the actions of the security guards on one of its wards.

The neurological and geriatric psychiatry wards of Pitkäniemi Hospital

The neurological and geriatric psychiatry wards of Pitkäniemi Hospital were informed of the Ombudsman's view, according to which patients in both involuntary and voluntary treatment should, if they so wish, have access to outdoor exercise daily.

A draft report on the visit was sent to the hospital for comments.

Comment: *The hospital reported that it had taken action related to many viewpoints contained in the draft. These viewpoints concerned such issues as more detailed monitoring of the patients' outdoor exercise, placement of acute patients in single rooms, providing grounds for decisions to take patients in for observation as well as rectifying shortcomings observed in the seclusion room.*

In a final report the Ombudsman also recommended that the patients be informed better of their rights, including the right to obtain a second opinion on continuing their treatment at the hospital's cost and the right to, at their own cost, be assessed by a doctor chosen by them. Patients in involuntary treatment should also be clearly informed of their right to receive a decision that can be appealed on having their possessions removed from them if they do not accept the ward's practice of keeping the patients' possessions in the office.

The Ombudsman pointed out that any assaults committed on the wards should, as a rule, be reported to the police. The hospital should have instructions on documenting the injuries of a patient brought in by the police.

The Ombudsman also expressed his view that a security guard cannot perform duties that belong to health care professionals.

Following the visit, **the Ombudsman launched an own-initiative investigation** of the following matters:

- The Regional State Administrative Agency was asked to establish if the staffing ratio of Pitkäniemi Hospital is adequate.
- The Regional State Administrative Agency was asked to investigate if keeping a patient restrained for a long period had been appropriate.
- The Ministry of Social Affairs and Health was asked to investigate and give a statement on how a patient who has lost the ability for self-determination is represented in connection with an important decision on his or her treatment and commitment to involuntary treatment.

A view from a balcony at the geriatric psychiatry ward in Pitkäniemi Hospital (visit on 20 April 2016).

The acute psychiatric ward of Vammala Hospital

The NPM conducted a pre-announced visit in the acute psychiatric ward of Vammala Hospital in spring 2016. The ward did not have a brochure intended for patients and their families that would explain the operation of the ward and the patient's rights in as plain a language as possible.

↳ The staff was instructed to familiarise themselves with the brochure available on Valvira's website titled "Information about involuntary psychiatric care and patient rights".

- **The Ombudsman felt that it would be a good idea** to establish in advance where the hospital should obtain a second opinion on the need to continue treatment in case of patients coming from several different municipalities.

- The ward's seclusion room did not have a clock that would enable a patient placed in the room to keep track of time.

↳ **The Ombudsman recommended** that a clock be purchased.

- During the visit, it turned out that the seclusion room was used very little.

↳ **The Ombudsman found** this a positive development that could finally lead to abandoning the seclusion room altogether.

- **The Ombudsman welcomed** the green area built in the institution's courtyard that enabled also those patients whose freedom of movement is restricted to take outdoor exercise independently.

A courtyard at Vammala Hospital where psychiatric patients can spend time outdoors independently (visit on 19 April 2016).

The psychiatric wards of South Karelia Central Hospital

The NPM visited the psychiatric wards of South Karelia Central Hospital in late 2016. The NPM also visited the hospital's outpatient and assessment clinic for mental health patients, which provides detoxification and opioid replacement therapy. A psychiatric nurse participated in the visit to psychiatric wards as an external expert.

The hospital was informed in advance of a two-month period during which the visit would take place. This made it possible to obtain documents from the hospital and peruse them in advance. Before the visit, the NPM also contacted the patient ombudsman and the Regional State Administrative Agency, from whom a lot of useful information was obtained on aspects to which special attention should be paid on the visit.

- In particular, the visit focused on the fact that, even if the hospital has managed to clearly reduce the use of different restrictive measures, an increase can be seen in the statistics since 2014.

  In the final discussion, this question was addressed, noting that the stalling of positive development may partly have taken place because the issue has not been actively brought up.

- The unit did not have a plan for reducing the use of coercion in which quantitative and qualitative targets would be set for restrictive measures.

  The NPM noted that the unit should prepare such a plan.

- Instructions for special situations had been prepared for the unit.

  The NPM suggested that the instructions should be turned into a user-friendly manual for the wards. This would promote consistent action by all nurses and, for example, help them understand how soon the doctors should come and check a patient.

  Comment: *The chief physician explained that the doctors on call had been given instructions on this matter, but the nurses did not seem to know what they can expect of the doctors.*

- The NPM drew the unit's attention to the fact that the ward could have several patients in the same room, while other rooms were vacant.

  The NPM pointed out that in the interest of the patients' recovery it could be considered an appropriate goal to spread the patients into the rooms evenly.

- Other patients in the ward called at the nurse's station, which had a direct visual link with the seclusion room through the security camera monitor.

The NPM focused attention on the risk of compromising the privacy of patients placed in the seclusion room.

The emergency care units of somatic hospitals

As in previous years, the Ombudsman felt it was important to visit the emergency care units of somatic hospitals, which use so-called secure rooms. These rooms are used for patients brought to emergency care services who, for example because they are aggressive or confused, cannot be placed among other emergency patients.

This situation is a problem because there are no legislation on seclusion in somatic health care. However, secluding a patient may sometimes be justified under emergency or self-defence provisions. Usually, these situations involve an emergency where it is necessary to restrict the patient's freedom to protect either his or her own or other persons' health or safety.

In his legal practice, the Ombudsman' has also required that the legal provisions and ethical norms that guide the actions of doctors and other health care professionals (so-called double standard requirement) must be taken into account in these situations. Additionally, the procedure may not violate the patient's human dignity. Having appropriate equipment in the seclusion room is of major importance when assessing if a patient's seclusion has, as a whole, been implemented in a manner that qualifies as dignified treatment and high-quality health and medical care. As minimum requirements that a secure room must fulfil can be regarded the conditions laid down in the Mental Health Act for the seclusion of a psychiatric patient.

A patient placed in a secure room must be monitored continuously. This means that the patient must be monitored by visiting the seclusion room in person and observing the patient through a video link with image and audio.

Different emergency care units have numerous security rooms, and they are used regularly. Regardless of this, patients rarely complain to the Ombudsman about their placement in a secure room or their treatment while in there.

In 2016, the NPM visited the emergency care units of two university hospitals. Both visits were unannounced and took place in the evening time.

In the case of THE EMERGENCY CARE SERVICES OF TURKU UNIVERSITY HOSPITAL, the NPM were satisfied that the secure room was not used in breach of the principles described above. On the other hand, there was scope for improvement in cooperation between various authorities.

- The observations made during the visit indicated that the emergency care unit personnel did not have a clear idea of how other authorities (such as the police and the detoxification centre) operate, even if their customers are partly the same.

The Deputy-Ombudsman pointed out that by increasing cooperation between the authorities, limited resources could be used more efficiently and appropriately.

A secure room at the Tampere University Hospital (Tays) First Aid Unit Acuta (unannounced visit on 19 April 2016).

A visit to THE FIRST AID UNIT ACUTA IN TAMPERE UNIVERSITY HOSPITAL left the NPM unsure of whether or not patients placed in the secure room are monitored appropriately. For this reason, the unit was asked to submit patient documents concerning patients placed in the secure room to the Ombudsman after the visit.

- Several monitoring entries had been made on each patient, the time intervals of which varied from 10 minutes to several hours, while the longest interval was over three hours.

There is no general official policy on the time intervals of monitoring a secluded patient. In principle, the patient should be monitored as indicated by his or her situation. While camera surveillance may reduce the need to visit the patient, it does not eliminate the need for personal visits. In his previous comments, the Ombudsman has expressed the view that the patient's monitoring is insufficient if his or her status is only checked every half an hour.

Appropriate records must always be kept of the monitoring.

Prisoners' health care

Prisoners' health care was transferred to the administrative branch of the Ministry of Social Affairs and Health at the beginning of 2016. The Prisoners' Health Care Unit operates in connection with the National Institute for Health and Welfare (THL). At the same time, the powers of Valvira and the Regional State Administrative Agencies were expanded to also cover the prisoners' health care organisation. In practice, the supervision has been centralised to AVI Northern Finland, which conducts guidance and assessment visits to the outpatient clinics and hospitals of the Prisoners' Health Care Unit on its own or together with Valvira. By the end of the year, 12 of these units had been visited.

During the reporting year, the NPM made pre-announced visits to Turku and Kylmäkoski outpatient clinics of the Prisoners' Health Care Unit. An external expert participated in the latter visit. In addition to these, an inspector from the Office of the

Parliamentary Ombudsman conducted a pre-announced visit to the Prison Hospital in Hämeenlinna. The purpose of the visit was to investigate a matter initiated as a complaint.

The outpatient clinic is almost always visited at the same time as the relevant prison. In this connection, prisoners are usually heard, gaining an impression of their experiences of the outpatient clinic's operation and of aspects to which special attention should be paid when visiting the clinic.

In Turku outpatient clinic of the Prisoners' Health Care Unit, keeping the clinic open during the weekends and having a doctor in attendance every weekday were considered positive aspects. The NPM also welcomed the fact that the prisoners have access to a dentist four days a week and that there is no queue for dental care.

- The Ombudsman observed that incoming prisoners' check-ups are almost exclusively based on an extensive interview. The form used in the check-ups does not contain questions about injuries or a body chart in which injuries could be recorded.

  The Ombudsman emphasised that the CPT report on Finland drew attention to the procedure of recording injuries claimed to result from inappropriate treatment. This comment also concerned incoming prisoners' check-ups.

  The Ombudsman also pointed out that the persons conducting the check-up should take into account the possibility that the prisoner may have been subjected to physical violence before arrival in the prison while in the custody of another authority as a person deprived of his or her liberty. The Ombudsman stressed that if appropriate documentation in this phase is lacking, the possibility of referring the matter to investigation by the authorities, if this is what the victim would like, is usually lost – or at least the investigation is hampered. This is important in terms of the legal protection of persons deprived of their liberty and, on the other hand, of those authorities or other actors at whom suspicions are levelled.

  The Ombudsman recommended that any signs of physical violence be discussed with the patient and that their absence is also recorded in the patient documents. If injuries are found, an appointment with a doctor should be made for the prisoner, so that the injuries can be examined and recorded appropriately.

- A screening of treatment needs had been carried out for all inmates serving a life sentence in the prison in the previous year.

  The Ombudsman felt that this was a step in the right direction. The clinic was encouraged to continue this type of screening activities at regular intervals. **The Ombudsman also recommended** that the clinic carry out a screening of the treatment needs of other prisoners serving long sentences.

- When prisoners were interviewed, they expressed their dissatisfaction at not receiving a response to their inquiry forms.

  ↳ The Ombudsman does not find the clinic's action related to responding to the inquiry forms lawful if the general practice is not to inform the patients of the time of their doctor's appointment in advance. They should also be informed if the appointment is rescheduled. In this respect, prisoners should not placed in a different position from other patients. The Ombudsman found it important that the clinic's practice related to informing patients of the times of their doctor's appointments, and possibly other appointments, be changed so that it is compliant with the law.

- Whether or not the form currently in use is suitable in general for contacting the clinic was also discussed during the visit. This applied to all Prisoners' Health Care Units.

  ↳ The Ombudsman noted he would take it up separately with the National Institute for Health and Welfare and the Prisoners' Health Care Unit, rather than assessing the question any further. However, the Ombudsman encouraged the clinic in continuing its efforts to design its own form that would only relate to health care issues. This would be another way of helping to streamline the patients' interaction with the clinic.

  ↳ The Ombudsman also recommended that the clinic work together with the prison to ensure that the confidentiality of the prisoners' interactions with the health care services is not compromised. If the inquiry form is the prisoner's only way of contacting the health care services, attention should be paid to secrecy in its use. As an example, he cited a prison where messages intended for the clinic can be placed in a locked letterbox intended for this purpose.

- The NPM were told that a prisoner placed in observation, or isolating observation, is always visited at the time of the placement. Subsequently, the prisoner is visited as required. A prisoner in solitary confinement is visited roughly once a week.

  ↳ The imprisonment act (*vankeuslaki, 767/2005*) does not contain specific provisions on how often the health care services should visit these prisoners. The CPT standards require that the health care services visit a prisoner placed in isolation immediately and, subsequently, at least once a day. The Ombudsman found it important that the clinic visits a prisoners placed under observation or isolating observation every day. The Ombudsman also recommended that a prisoner placed in solitary confinement or in isolation be visited regularly.

- On a visit to THE KYLMÄKOSKI OUTPATIENT CLINIC OF THE PRISONERS' HEALTH CARE UNIT, particular attention was paid to the fact that the clinic has less access to a doctor's services than when the Ombudsman last visited it in 2013. A doctor only visits Kylmäkoski once or twice a week and has time to see no more than a few patients during one working day, as his or her working time is mainly taken up by written consultations. This naturally results in a queue for doctor's appointments and continuously increases the nurses' daily workload.

- Additionally, no psychiatrist visited the clinic, and outside psychiatric services were used little. Dental health services had also been outsourced. The visits of the dentist, who came from Helsinki, were not regular.

- The nurses had time to conduct at least a brief check-up on all new prisoners.

The addition of a section on possible signs of violence to the check list developed for this purpose was proposed.

4
OTHER ACTIVITIES

4.1 Statements issued

The criminal sanctions sector

In the criminal sanctions sector, three statements were issued during the reporting year to the Department of Criminal Policy at the Ministry of Justice. One of these concerned ALTERNATIVES AND ARRANGEMENTS FOR REMAND IMPRISONMENT. The Deputy-Ombudsman found justified and supported the proposals put forward by the working group as options for remand imprisonment, which included an electronically supervised enhanced travel ban and house arrest. Through these methods, the use of deprivation liberty and the different harmful effects of remand imprisonment on the prisoner could be reduced.

On the subject of holding remand prisoners in the detention facilities of the police, the Deputy-Ombudsman noted that Finland, too, should achieve the goal of holding these prisoners in remand prisons after a decision on their imprisonment has been made. The Deputy-Ombudsman found it extremely important that the working group's proposals be implemented. The processing of the matter has advanced since that time, and the government has submitted a proposal on it to the Parliament (HE 252/2016 vp). The Office of the Parliamentary Ombudsman has issued a statement on the proposal to the Legal Affairs Committee.

Another important issue relevant to the rights of persons deprived of their liberty on which the Deputy-Ombudsman issued a statement to the Ministry of Justice concerned RESTRAINING PRISONERS DURING TRANSPORT. The Deputy-Ombudsman did not find the contents of the draft bill justified as it proposed dropping individual consideration. Under the draft bill, all prisoners travelling together could be restrained on certain conditions, without individual consideration in the case of each prisoner.

The Deputy-Ombudsman noted that the proposal was problematic in terms of the Constitution, in breach of international recommendations concerning persons having been deprived of their liberty, and inconsistent with international monitoring bodies' practice. This matter has also progressed to the Parliament, and the Office of the Parliamentary Ombudsman issued statements on the government bill (HE 263/2016 vp) to the Legal Affairs Committee and the Constitutional Law Committee in early 2017.

Alien affairs

Several amendments were made to the ALIENS ACT in 2016. The provisions that concern district court hearings on taking foreign nationals in custody were lightened. In the future, cases that concern holding a foreign national in custody will only be heard again by the district court on request of the person in custody. Previously, such a case had to be brought before the court every two weeks. The Ombudsman issued a statement on this matter both in the drafting stage and during the parliamentary hearing. In addition, the Ombudsman was consulted on the legislative amendment by parliamentary committees.

In connection with the RIGHTS OF PERSONS WITH DISABILITIES, the Ombudsman issued a statement to the Constitutional Law Committee on a government bill on special care for people with disabilities (HE 96/2015 vp). The purpose of the amendment is to reinforce the right to self-determination of persons in special care and to reduce the use of restrictive measures. The provisions entered into force in June 2016.

4.2 Own-initiative investigations and decisions issued on them

The Ombudsman ordered that three Helsinki District Court judges and the director of METSÄLÄ DETENTION UNIT *be prosecuted* for negligent breach of official duty. The charge is based on their failure to process decisions to keep foreigners taken in custody in isolation as required by the law. This came to light as the Ombudsman visited the detention unit in December 2014.

The Deputy-Ombudsman initiated an own-initiative investigation on ELECTROSHOCK WEAPON USE BY THE POLICE. In his decision on the matter, he proposed that the National Police Board prepare guidelines on electroshock weapon use. Attention should also be paid to the quality of training – including in-service training – and its supervision. The possibilities of recording electroshock weapon use by a camera should, additionally, be examined and assessed. These aspects are significant for the legal protection of a person against whom coercive measures are used and also an individual police officer. Initial reports on electroshock weapon use were presented to the Deputy-Ombudsman in connection with a visit to the National Police Board.

In connection with a visit to a POLICE PRISON, it was found that the prison continues using a so-called RESTRAINT BED that the CPT had criticised on its visit in 2014. The CPT had recommended that the use of the restraint bed be discontinued immediately. In Finland's response to the CPT, the use of the bed was considered acceptable. The Deputy-Ombudsman launched an own-initiative investigation on this matter and requested information from the National Police Board on the use of the restraint bed and any instructions concerning it. A detoxification centre located beside the police prison was also requested to provide information on how its personnel participate in assessing and monitoring the state of health of a person tied to the restraint bed. The processing of this matter remains unfinished.

During the reporting year, the Deputy-Ombudsman asked the National Police Board to submit to him A REPORT ON DEATHS OF PERSONS DEPRIVED OF THEIR LIBERTY IN POLICE CUSTODY in 2000–2016. A report on whether these cases led to pre-trial investigations, prosecutions or sentences was also requested. Additionally, information on how the police strive to prevent suicides and deaths of persons deprived of their liberty during transport and whether instructions or training on this issue have been

provided was also requested. The matter is still pending at the Office of the Parliamentary Ombudsman.

In the *criminal sanctions sector*, the practice of an open prison that imposed a disciplinary sanction on prisoners who refused to provide urine samples was investigated as a separate issue. In the decision issued on this matter, the Deputy-Ombudsman noted that the practice was not based on law and that it was also not possible to provide for a disciplinary punishment on this basis in the prison rules. At the same time, the situation in other prisons besides the open prison in question was investigated. No other open prison had a similar practice.

4.3 Legislative proposals

When inspecting documents related to a prison visit, it was found that a warden had, when transporting a prisoner, brought a pillowcase to stop the prisoner from spitting. When it was observed that the prisoner had collected a mouthful of saliva during transport, the prisoner's face was covered with a pillowcase. This action was considered problematic, which is why an own-initiative investigation of how the Criminal Sanctions Agency is prepared for the need for such protection measures was launched. This individual case will not be investigated, as it is pending as a criminal matter in the case of this prisoner.

The information provided indicated that following the observations made during the visit, the prison had given up using pillowcases and purchased hoods specifically designed to prevent spitting. The Criminal Sanctions Agency had not issued separate instructions on anti-spitting devices.

In his decision, the Deputy-Ombudsman found that preventing spitting by mechanical devices is a restriction of fundamental rights that interferes with the prisoner's personal integrity, and legislative provisions that are carefully limited and sufficiently detailed should be laid down on it. The current legislation contains no provisions on protection measures and use of force to prevent spitting, or the devices used for this. The Deputy-Ombudsman informed the Ministry of Justice of THE ABSENCE OF REGULATION ON DEVICES THAT PREVENT SPITTING. He proposed that the Ministry of Justice consider if more specific legislation on protection against spitting is needed.

On a visit to a *child welfare unit*, it was noted that under THE CHILD WELFARE ACT, the staff does not have a right to order a child to strip. Asking a child to strip is a bodily search, not a physical examination referred to in the Child Welfare Act. On the other hand, the Child Welfare Act provision on bodily search does not give a right to strip the child. The Deputy-Ombudsman submitted a proposal to the Ministry of Social Affairs and Health aiming to assess if the provision on bodily search should be reviewed, at least in the case of young people who are the most demanding to care for.

4.4 Proposals on recompense

In his role as a supervisor of fundamental rights, the Ombudsman can make proposals concerning recompense for human rights violations. When it is no longer possible to rectify a problem, the Ombudsman may suggest that an authority make an apology to the person whose rights have been violated, or that financial compensation be considered. The proposals have in most cases led to a positive outcome.

Below, some examples of proposals on recompense made in 2016 are given that are associated with violations against persons deprived of their liberty or with their treatment.

No justifications required by law for placing a PRISONER IN OBSERVATION were given, no decision was made on placing the prisoner in observation, and the health care staff was not informed of the placement. In addition, the manner in which the strip search that proceeded the observation and the conditions in which the prisoner was kept were inappropriate. The Deputy-Ombudsman found it credible that the prisoner had been cold at night in the isolation cell in scant clothing and without a blanket. The Deputy-Ombudsman proposed that the State of Finland pay the prisoner compensation for being placed in observation without proper grounds.

The Ombudsman proposed that a PATIENT be recompensed for a chain of events that started when the patient left a central hospital's JOINT EMERGENCY SERVICES. A doctor had been in breach of the Mental Health Act by not ensuring, when requesting executive assistance from the police, that a health care professional would accompany the patient during transport. The patient was then locked up in the secure room of the emergency services unit, which did not appear necessary. No decision made by a doctor on the patient's seclusion was found in the documents. The monitoring of the secluded patient was also insufficient. According to the Ombudsman, this had compromised and violated the patient's fundamental rights to personal freedom and safety, and the Ombudsman thus recommended that recompense be paid for the violations.

The possibilities of A PATIENT IN INVOLUNTARY CARE of contacting their legal representative were restricted without grounds laid down in the Mental Health Act and following an incorrect procedure. According to the Ombudsman, this could constitute a violation of the protection of privacy enshrined in the Constitution and the European Human Rights Convention. The patient's psychotic symptoms were not a sufficient reason to restrict contact with a legal representative by over 24 hours, especially when the patient no longer was secluded. The Ombudsman requested that the hospital district consider if it could compensate the patient for this violation of rights.

5
ANNEXES

Constitutional Provisions pertaining to Parliamentary Ombudsman of Finland

11 June 1999 (731/1999), entry into force 1 March 2000

Section 27
Eligilibity and qualifications for the office of Representative

Everyone with the right to vote and who is not under guardianship can be a candidate in parliamentary elections.

A person holdin military office cannot, however, be elected as a Representative.

The Chancellor of Justice of the Government, the Parliamentary Ombudsman, a Justice of the Supreme Court or the Supreme Administrative Court, and the Prosecutor-General cannot serve as representatives. If a Representative is elected President of the Republic or appointed or elected to one of the aforesaid offices, he or she shall cease to be a Representative from the date of appointment or election. The office of a Representative shall cease also if the Representative forfeits his or her eligibility.

Section 38
Parliamentary Ombudsman

The Parliament appoints for a term of four years a Parliamentary Ombudsman and two Deputy Ombudsmen, who shall have outstanding knowledge of law. A Deputy Ombudsman may have a substitute as provided in more detail by an Act. The provisions on the Ombudsman apply, in so far as appropriate, to a Deputy Ombudsman and to a Deputy Ombudsman's a substitute. (802/2007, entry into force 1.10.2007)

The Parliament, after having obtained the opinion of the Constitutional Law Committee, may, for extremely weighty reasons, dismiss the Ombudsman before the end of his or her term by a decision supported by at least two thirds of the votes cast.

Section 48
Right of attendance of Ministers, the Ombudsman and the Chancellor of Justice

Minister has the right to attend and to participate in debates in plenary sessions of the Parliament even if the Minister is not a Representative. A Minister may not be a member of a Committee of the Parliament. When performing the duties of the President of the Republic under section 59, a Minister may not participate in parliamentary work.

The Parliamentary Ombudsman and the Chancellor of Justice of the Government may attend and participate in debates in plenary sessions of the Parliament when their reports or other matters taken up on their initiative are being considered.

Section 109
Duties of the Parliamentary Ombudsman

The Ombudsman shall ensure that the courts of law, the other authorities and civil servants, public employees and other persons, when the latter are performing a public task, obey the law and fulfil their obligations. In the performance of his or her duties, the Ombudsman monitors the implementation of basic rights and liberties and human rights.

The Ombudsman submits an annual report to the Parliament on his or her work, including observations on the state of the administration of justice and on any shortcomings in legislation.

Section 110
The right of the Chancellor of Justice and the Ombudsman to bring charges and the division of responsibilities between them

A decision to bring charges against a judge for unlawful conduct in office is made by the Chancellor of Justice or the Ombudsman. The Chancellor of Justice and the Ombudsman may prosecute or order that charges be brought also in other matters falling within the purview of their supervision of legality.

Provisions on the division of responsibilities between the Chancellor of Justice and the Ombudsman may be laid down by an Act, without, however, restricting the competence of either of them in the supervision of legality.

Section 111
The right of the Chancellor of Justice and Ombudsman to receive information

The Chancellor of Justice and the Ombudsman have the right to receive from public authorities or others performing public duties the information needed for their supervision of legality.

The Chancellor of Justice shall be present at meetings of the Government and when matters are presented to the President of the Republic in a presidential meeting of the Government. The Ombudsman has the right to attend these meetings and presentations.

Section 112
Supervision of the lawfulness of the official acts of the Government and the President of the Republic

If the Chancellor of Justice becomes aware that the lawfulness of a decision or measure taken by the Government, a Minister or the President of the Republic gives rise to a comment, the Chancellor shall present the comment, with reasons, on the aforesaid decision or measure. If the comment is ignored, the Chancellor of Justice shall have the comment entered in the minutes of the Government and, where necessary, undertake other measures. The Ombudsman has the corresponding right to make a comment and to undertake measures.

If a decision made by the President is unlawful, the Government shall, after having obtained a statement from the Chancellor of Justice, notify the President that the decision cannot be implemented, and propose to the President that the decision be amended or revoked.

Section 113
Criminal liability of the President of the Republic

If the Chancellor of Justice, the Ombudsman or the Government deem that the President of the Republic is guilty of treason or high treason, or a crime against humanity, the matter shall be communicated to the Parliament. In this event, if the Parliament, by three fourths of the votes cast, decides that charges are to be brought, the Prosecutor-General shall prosecute the President in the High Court of Impeachment and the President shall abstain from office for the duration of the proceedings. In other cases, no charges shall be brought for the official acts of the President.

Section 114
Prosecution of Ministers

A charge against a Member of the Government for unlawful conduct in office is heard by the High Court of Impeachment, as provided in more detail by an Act.

The decision to bring a charge is made by the Parliament, after having obtained an opinion from the Constitutional Law Committee concerning the unlawfulness of the actions of the Minister. Before the Parliament decides to bring charges or not it shall allow the Minister an opportunity to give an explanation. When considering a matter of this kind the Committee shall have a quorum when all of its members are present.

A Member of the Government is prosecuted by the Prosecutor-General.

Section 115
Initiation of a matter concerning the legal responsibility of a Minister

An inquiry into the lawfulness of the official acts of a Minister may be initiated in the Constitutional Law Committee on the basis of:

1) A notification submitted to the Constitutional Law Committee by the Chancellor of Justice or the Ombudsman;
2) A petition signed by at least ten Representatives; or
3) A request for an inquiry addressed to the Constitutional Law Committee by another Committee of the Parliament.

The Constitutional Law Committee may open an inquiry into the lawfulness of the official acts of a Minister also on its own initiative.

Section 117
Legal responsibility of the Chancellor of Justice and the Ombudsman

The provisions in sections 114 and 115 concerning a member of the Government apply to an inquiry into the lawfulness of the official acts of the Chancellor of Justice and the Ombudsman, the bringing of charges against them for unlawful conduct in office and the procedure for the hearing of such charges.

Parliamentary Ombudsman Act

14 March 2002 (197/2002)

CHAPTER 1
Oversight of legality

Section 1
Subjects of the Parliamentary Ombudsman's oversight

(1) For the purposes of this Act, subjects of oversight shall, in accordance with Section 109 (1) of the Constitution of Finland, be defined as courts of law, other authorities, officials, employees of public bodies and also other parties performing public tasks.

(2) In addition, as provided for in Sections 112 and 113 of the Constitution, the Ombudsman shall oversee the legality of the decisions and actions of the Government, the Ministers and the President of the Republic. The provisions set forth below in relation to subjects of oversight apply in so far as appropriate also to the Government, the Ministers and the President of the Republic.

Section 2
Complaint

(1) A complaint in a matter within the Ombudsman's remit may be filed by anyone who thinks a subject has acted unlawfully or neglected a duty in the performance of their task.

(2) The complaint shall be filed in writing. It shall contain the name and contact particulars of the complainant, as well as the necessary information on the matter to which the complaint relates.

Section 3
Investigation of a complaint (20.5.2011/535)

(1) The Ombudsman shall investigate a complaint if the matter to which it relates falls within his or her remit and if there is reason to suspect that the subject has acted unlawfully or neglected a duty or if the Ombudsman for another reason takes the view that doing so is warranted.

(2) Arising from a complaint made to him or her, the Ombudsman shall take the measures that he or she deems necessary from the perspective of compliance with the law, protection under the law or implementation of fundamental and human rights. Information shall be procured in the matter as deemed necessary by the Ombudsman.

(3) The Ombudsman shall not investigate a complaint relating to a matter more than two years old, unless there is a special reason for doing so.

(4) The Ombudsman must without delay notify the complainant if no measures are to be taken in a matter by virtue of paragraph 3 or because it is not within the Ombudsman's remit, it is pending before a competent authority, it is appealable through regular appeal procedures, or for another reason. The Ombudsman can at the same time inform the complainant of the legal remedies available in the matter and give other necessary guidance.

(5) The Ombudsman can transfer handling of a complaint to a competent authority if the nature of the matter so warrants. The complainant must be notified of the transfer. The authority must inform the Ombudsman of its decision or other measures in the matter within the deadline set by the Ombudsman. Separate provisions shall apply to a transfer of a complaint between the Parliamentary Ombudsman and the Chancellor of Justice of the Government.

Section 4
Own initiative

The Ombudsman may also, on his or her own initiative, take up a matter within his or her remit.

Section 5
Inspections (28.6.2013/495)

(1) The Ombudsman shall carry out the onsite inspections of public offices and institutions necessary to monitor matters within his or her remit. Specifically, the Ombudsman shall carry out inspections in prisons and other closed institutions to oversee the treatment of inmates, as well as in the various units of the Defence Forces and Finland's military crisis management organisation to monitor the treatment of conscripts, other persons doing their military service and crisis management personnel.

(2) In the context of an inspection, the Ombudsman and officials in the Office of the Ombudsman assigned to this task by the Ombudsman have the right of access to all premises and information systems of the inspection subjeft, as well as the right to have confidential discussions with the personnel of the office or institution, persons serving there and its inmates.

Section 6
Executive assistance

The Ombudsman has the right to executive assistance free of charge from the authorities as he or she deems necessary, as well as the right to obtain the required copies or printouts of the documents and files of the authorities and other subjects.

Section 7
Right of the Ombudsman to information

The right of the Ombudsman to receive information necessary for his or her oversight of legality is regulated by Section 111 (1) of the Constitution.

Section 8
Ordering a police inquiry or a pre-trial investigation (22.7.2011/811)

The Ombudsman may order that a police inquiry, as referred to in the Police Act (872/2011), or a pre-trial investigation, as referred to in the Pre-trial Investigations Act (805/2011), be carried out in order to clarify a matter under investigation by the Ombudsman.

Section 9
Hearing a subject

If there is reason to believe that the matter may give rise to criticism as to the conduct of the subject, the Ombudsman shall reserve the subject an opportunity to be heard in the matter before it is decided.

Section 10
Reprimand and opinion

(1) If, in a matter within his or her remit, the Ombudsman concludes that a subject has acted unlawfully or neglected a duty, but considers that a criminal charge or disciplinary proceedings are nonetheless unwarranted in this case, the Ombudsman may issue a reprimand to the subject for future guidance.

(2) If necessary, the Ombudsman may express to the subject his or her opinion concerning what constitutes proper observance of the law, or draw the attention of the subject to the requirements of good administration or to considerations of promoting fundamental and human rights.

(3) If a decision made by the Parliamentary Ombudsman referred to in Subsection 1 contains an imputation of criminal guilt, the party having been issued with a reprimand has the right to have the decision concerning criminal guilt heard by a court of law. The demand for a court hearing shall be submitted to the Parliamentary Ombudsman in writing within 30 days of the date on which the party was notified of the reprimand. If notification of the reprimand is served in a letter sent by post, the party shall be deemed to have been notified of the reprimand on the seventh day following the dispatch of the letter unless otherwise proven. The party having been issued with a reprimand shall be informed without delay of the time and place of the court hearing, and of the fact that a decision may be given in the matter in their absence. Otherwise the provisions on court proceedings in criminal matters shall be complied with in the hearing of the matter where applicable. (22.8.2014/674)

Section 11
Recommendation

(1) In a matter within the Ombudsman's remit, he or she may issue a recommendation to the competent authority that an error be redressed or a shortcoming rectified.

(2) In the performance of his or her duties, the Ombudsman may draw the attention of the Government or another body responsible for legislative drafting to defects in legislation or official regulations, as well as make recommendations concerning the development of these and the elimination of the defects.

CHAPTER 1 a
National Preventive Mechanism (NPM) (28.6.2013/495)

Section 11 a
National Preventive Mechanism (28.6.2013/495)

The Ombudsman shall act as the National Preventive Mechanism referred to in Article 3 of the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (International Treaty Series 93/2014).

Section 11 b
Inspection duty (28.6.2013/495)

(1) When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman inspects places where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence (place of detention).

(2) In order to carry out such inspections, the Ombudsman and an official in the Office of the Ombudsman assigned to this task by the Ombudsman have the right of access to all premises and information systems of the place of detention, as well as the right to have confidential discussions with persons having been deprived of their liberty, with the personnel of the place of detention and with any other persons who may supply relevant information.

Section 11 c
Access to information (28.6.2013/495)

Notwithstanding the secrecy provisions, when carrying out their duties in capacity of the National Preventive Mechanism the Ombudsman and an official in the Office of the Ombudsman assigned to this task by the Ombudsman have the right to receive from authorities and parties maintaining the places of detention information about the number of persons deprived of their liberty, the number and locations of the facilities, the treatment of persons deprived of their liberty and the conditions in which they are kept, as well as any other information necessary in order to carry out the duties of the National Preventive Mechanism.

Section 11 d
Disclosure of information (28.6.2013/495)

In addition to the provisions contained in the Act on the Openness of Government Activities (621/1999) the Ombudsman may, notwithstanding the secrecy provisions, disclose information about persons having been deprived of their liberty, their treatment and the conditions in which they are kept to a Subcommittee referred to in Article 2 of the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

Section 11 e
Issuing of recommendations (28.6.2013/495)

When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman may issue the subjects of supervision recommendations intended to improve the treatment of persons having been deprived of their liberty and the conditions in which they are kept and to prevent torture and other cruel, inhuman or degrading treatment or punishment.

Section 11 f
Other applicable provisions (28.6.2013/495)

In addition, the provisions contained in Sections 6 and 8–11 herein on the Ombudsman's action in the oversight of legality shall apply to the Ombudsman's activities in his or her capacity as the National Preventive Mechanism.

Section 11 g
Independent Experts (28.6.2013/495)

(1) When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman may rely on expert assistance. The Ombudsman may appoint as an expert a person who has given his or her consent to accepting this task and who has particular expertise relevant to the inspection duties of the National Preventive Mechanism. The expert may take part in conducting inspections referred to in Section 11 b, in which case the provisions in the aforementioned section and Section 11 c shall apply to their competence.

(2) When the expert is carrying out his or her duties referred to in this Chapter, the provisions on criminal liability for acts in office shall apply. Provisions on liability for damages are contained in the Tort Liability Act (412/1974).

Section 11 h
Prohibition of imposing sanctions (28.6.2013/495)

No punishment or other sanctions may be imposed on persons having provided information to the National Preventive Mechanism for having communicated this information.

CHAPTER 2
Report to the Parliament and declaration of interests

Section 12
Report

(1) The Ombudsman shall submit to the Parliament an annual report on his or her activities and the state of administration of justice, public administration and the performance of public tasks, as well as on defects observed in legislation, with special attention to implementation of fundamental and human rights.

(2) The Ombudsman may also submit a special report to the Parliament on a matter he or she deems to be of importance.

(3) In connection with the submission of reports, the Ombudsman may make recommendations to the Parliament concerning the elimination of defects in legislation. If a defect relates to a matter under deliberation in the Parliament, the Ombudsman may also otherwise communicate his or her observations to the relevant body within the Parliament.

Section 13
Declaration of interests (24.8.2007/804)

(1) A person elected to the position of Ombudsman, Deputy-Ombudsman or as a substitute for a Deputy-Ombudsman shall without delay submit to the Parliament a declaration of business activities and assets and duties and other interests which may be of relevance in the evaluation of his or her activity as Ombudsman, Deputy-Ombudsman or substitute for a Deputy-Ombudsman.

(2) During their term in office, the Ombudsman the Deputy-Ombudsmen and the substitute for a Deputy-Ombudsman shall without delay declare any changes to the information referred to in paragraph (1) above.

CHAPTER 3
General provisions on the Ombudsman, the Deputy-Ombudsmen and the Director of the Human Rights Centre (20.5.2011/535)

Section 14
Competence of the Ombudsman and the Deputy-Ombudsmen

(1) The Ombudsman has sole competence to make decisions in all matters falling within his or her remit under the law. Having heard the opinions of the Deputy-Ombudsmen, the Ombudsman shall also decide on the allocation of duties among the Ombudsman and the Deputy-Ombudsmen.

(2) The Deputy-Ombudsmen have the same competence as the Ombudsman to consider and decide on those oversight-of-legality matters that the Ombudsman has allocated to them or that they have taken up on their own initiative.

(3) If a Deputy-Ombudsman deems that in a matter under his or her consideration there is reason to issue a reprimand for a decision or action of the Government, a Minister or the President of the Republic, or to bring a charge against the President or a Justice of the Supreme Court or the Supreme Administrative Court, he or she shall refer the matter to the Ombudsman for a decision.

Section 15
Decision-making by the Ombudsman

The Ombudsman or a Deputy-Ombudsman shall make their decisions on the basis of drafts prepared by referendary officials, unless they specifically decide otherwise in a given case.

Section 16
Substitution (24.8.2007/804)

(1) If the Ombudsman dies in office or resigns, and the Parliament has not elected a successor, his or her duties shall be performed by the senior Deputy-Ombudsman.

(2) The senior Deputy-Ombudsman shall perform the duties of the Ombudsman also when the latter is recused or otherwise prevented from attending to his or her duties, as provided for in greater detail in the Rules of Procedure of the Office of the Parliamentary Ombudsman.

(3) Having received the opinion of the Constitutional Law Committee on the matter, the Parliamentary Ombudsman shall choose a substitute for a Deputy-Ombudsman for a term in office of not more than four years.

(4) When a Deputy-Ombudsman is recused or otherwise prevented from attending to his or her duties, these shall be performed by the Ombudsman or the other Deputy-Ombudsman as provided for in greater detail in the Rules of Procedure of the Office, unless the Ombudsman, as provided for in Section 19 a, paragraph 1, invites a substitute for a Deputy-Ombudsman to perform the Deputy-Ombudsman's tasks. When a substitute is performing the tasks of a Deputy-Ombudsman, the provisions of paragraphs (1) and (2) above concerning a Deputy-Ombudsman shall not apply to him or her.

Section 17
Other duties and leave of absence

(1) During their term of service, the Ombudsman and the Deputy-Ombudsmen shall not hold other public offices. In addition, they shall not have public or private duties that may compromise the credibility of their impartiality as overseers of legality or otherwise hamper the appropriate performance of their duties as Ombudsman or Deputy-Ombudsman.

(2) If the person elected as Ombudsman, Deputy-Ombudsman or Director of the Human Rights Centre holds a state office, he or she shall be granted leave of absence from it for the duration of their term of service as as Ombudsman, Deputy-Ombudsman or Director of the Human Rights Centre (20.5.2011/535).

Section 18
Remuneration

(1) The Ombudsman and the Deputy-Ombudsmen shall be remunerated for their service. The Ombudsman's remuneration shall be determined on the same basis as the salary of the Chancellor of Justice of the Government and that of the Deputy-Ombudsmen on the same basis as the salary of the Deputy Chancellor of Justice.

(2) If a person elected as Ombudsman or Deputy-Ombudsman is in a public or private employment relationship, he or she shall forgo the remuneration from that employment relationship for the duration of their term. For the duration of their term, they shall also forgo any other perquisites of an employment relationship or other office to which they have been elected or appointed and which could compromise the credibility of their impartiality as overseers of legality.

Section 19
Annual vacation

The Ombudsman and the Deputy-Ombudsmen are each entitled to annual vacation time of a month and a half.

Section 19 a
Substitute for a Deputy-Ombudsman (24.8.2007/804)

(1) A substitute for a Deputy-Ombudsman can perform the duties of a Deputy-Ombudsman if the latter is prevented from attending to them or if a Deputy-Ombudsman's post has not been filled. The Ombudsman shall decide on inviting a substitute to perform the tasks of a Deputy-Ombudsman. (20.5.2011/535)

(2) The provisions of this and other Acts concerning a Deputy-Ombudsman shall apply *mutatis mutandis* also to a substitute for a Deputy-Ombudsman while he or she is performing the tasks of a Deputy-Ombudsman, unless separately otherwise regulated.

CHAPTER 3 a
Human Rights Centre (20.5.2011/535)

Section 19 b
Purpose of the Human Rights Centre (20.5.2011/535)

For the promotion of fundamental and human rights there shall be a Human Rights Centre under the auspices of the Office of the Parliamentary Ombudsman.

Section 19 c
The Director of the Human Rights Centre (20.5.2011/535)

(1) The Human Rights Centre shall have a Director, who must have good familiarity with fundamental and human rights. Having received the Constitutional Law Committee's opinion on the matter, the Parliamentary Ombudsman shall appoint the Director for a four-year term.

(2) The Director shall be tasked with heading and representing the Human Rights Centre as well as resolving those matters within the remit of the Human Rights Centre that are not assigned under the provisions of this Act to the Human Rights Delegation.

Section 19 d
Tasks of the Human Rights Centre (20.5.2011/535)

(1) The tasks of the Human Rights Centre are:
1) to promote information, education, training and research concerning fundamental and human rights as well as cooperation relating to them;
2) to draft reports on implementation of fundamental and human rights;
3) to present initiatives and issue statements in order to promote and implement fundamental and human rights;
4) to participate in European and international cooperation associated with promoting and safeguarding fundamental and human rights;

5) to take care of other comparable tasks associated with promoting and implementing fundamental and human rights.

(2) The Human Rights Centre does not handle complaints.

(3) In order to perform its tasks, the Human Rights Centre shall have the right to receive the necessary information and reports free of charge from the authorities.

Section 19 e
Human Rights Delegation (20.5.2011/535)

(1) The Human Rights Centre shall have a Human Rights Delegation, which the Parliamentary Ombudsman, having heard the view of the Director of the Human Rights Centre, shall appoint for a four-year term. The Director of the Human Rights Centre shall chair the Human Rights Delegation. In addition, the Delegation shall have not fewer than 20 and no more than 40 members. The Delegation shall comprise representatives of civil society, research in the field of fundamental and human rights as well as other actors participating in the promotion and safeguarding of fundamental and human rights. The Delegation shall choose a deputy chair from among its own number. If a member of the Delegation resigns or dies mid-term, the Ombudsman shall appoint a replacement for him or her for the remainder of the term.

(2) The Office Commission of the Eduskunta shall confirm the remuneration of the members of the Delegation.

(3) The tasks of the Delegation are:

1) to deal with matters of fundamental and human rights that are far-reaching and important in principle;
2) to approve annually the Human Rights Centre's operational plan and the Centre's annual report;
3) to act as a national cooperative body for actors in the sector of fundamental and human rights.

(4) A quarum of the Delegation shall be present when the chair or the deputy chair as well as at least half of the members are in attendance. The opinion that the majority has supported shall constitute the decision of the Delegation. In the event of a tie, the chair shall have the casting vote.

(5) To organise its activities, the Delegation may have a work committee and sections. The Delegation may adopt rules of procedure.

CHAPTER 3 b
Other tasks (10.4.2015/374)

Section 19 f (10.4.2015/374)
Promotion, protection and monitoring of the implementation of the Convention on the Rights of Persons with Disabilities

The tasks under Article 33(2) of the Convention on the Rights of Persons with Disabilities concluded in New York in 13 December 2006 shall be performed by the Parliamentary Ombudsman, the Human Rights Centre and its Human Rights Delegation.

CHAPTER 4
Office of the Parliamentary Ombudsman and the detailed provisions

Section 20 (20.5.2011/535)
Office of the Parliamentary Ombudsman and detailed provisions

For the preliminary processing of cases for decision by the Ombudsman and the performance of the other duties of the Ombudsman as well as for the discharge of tasks assigned to the Human Rights Centre, there shall be an office headed by the Parliamentary Ombudsman.

Section 21
Staff Regulations of the Parliamentary Ombudsman and the Rules of Procedure of the Office (20.5.2011/535)

(1) The positions in the Office of the Parliamentary Ombudsman and the special qualifications for those positions shall be set forth in the Staff Regulations of the Parliamentary Ombudsman.

(2) The Rules of Procedure of the Office of the Parliamentary Ombudsman shall contain more detailed provisions on the allocation of tasks among the Ombudsman and the Deputy-Ombudsmen. Also determined in the Rules of Procedure shall be substitution arrangements for the Ombudsman, the Deputy-Ombudsmen and the Director of the Human Rights Centre as well as the duties of the office staff and the cooperation procedures to be observed in the Office.

(3) The Ombudsman shall confirm the Rules of Procedure of the Office having heard the views of the Deputy-Ombudsmen and the Director of the Human Rights Centre.

CHAPTER 5
Entry into force and transitional provision

Section 22
Entry into force

This Act enters into force on 1 April 2002.

Section 23
Transitional provision

The persons performing the duties of Ombudsman and Deputy-Ombudsman shall declare their interests, as referred to in Section 13, within one month of the entry into force of this Act.

Entry into force and application of the amending acts:

24.8.2007/804:
This Act entered into force on 1 October 2007.

20.5.2011/535
This Act entered into force on 1 January 2012 (Section 3 and Section 19 a, subsection 1 on 1 June 2011).

22.7.2011/811
This Act entered into force on 1 January 2014.

28.6.2013/495
This Act entered into force on 7 November 2014 (Section 5 on 1 July 2013).

22.8.2014/674
This Act entered into force on 1 January 2015.

10.4.2015/374
This Act entered into force on 10 June 2016.

Inspections within NPM mandate

* = inspection without advance notice

Police administration

- 26.1. Järvenpää police station, polis prison*
- 26.1. Hyvinkää police station, polis prison*
- 3.2. Porvoo police station, polis prison*
- 3.2. Vantaa main police station, polis prison*
- 21.4. Espoo Central Police Station, police prison*
- 19.5. Lahti Central Police Station, police prison*
- 6.6. Vaasa Central Police Station, police prison*
- 6.6. Pietarsaari police station, polis prison*
- 6.6. Kokkola police station, polis prison*
- 7.6. Ylivieska police station, polis prison*
- 7.6. Raahe police station, polis prison*
- 7.6. Oulu Central Police Station, police prison*
- 17.6. Porvoo police station, polis prison*
- 12.9. Åland Police Authority, police prison*, Mariehamn
- 8.11. Tampere Central Police Station, police prison
- 18.11. Vantaa Central Police Station, police prison, Tikkurila

Defence Forces and Border Guard

- 27.10. Karelia Brigade, Detention facilities for persons deprived of their liberty*
- 15.11. Satakunta Air Command, Detention facilities for persons deprived of their liberty*

Criminal sanctions

- 18.2. Criminal Sanctions Region of Southern Finland, supervision patrol activities, Vantaa
- 20.4. Käyrä prison*, Aura
- 21.-22.4. Turku Prison
- 27.4. Jokela Prison*
- 17.5. Riihimäki Prison
- 8.6. Suomenlinna Prison*
- 21.9. Ylitornio Prison
- 22.9. Oulu Prison
- 23.9. Kestilä Prison
- 23.9. Pelso Prison
- 2.-3.11. Mikkeli Prison
- 8.12. Kylmäkoski prison

Aliens affairs

- 21.12. City of Helsinki, Metsälä Reception Centre, Detention Unit, Helsinki

Social welfare

- 25.1. Pienkoti Aura, Jyväskylä (private child welfare unit)
- 18.2. Hovila youth home* (child welfare unit), Jyväskylä
- 13.4. Veikkari special children's home and school, Paimio
- 20.4. Tampere University Hospital (Tays), Support Centre for Disabled Care, Unit for Psychosocial Rehabilitation, Pitkäniemi Hospital, Nokia
- 12.5. Satakunta Hospital District, Antinkartano rehabilitation centre (rehabilitation and research centre for intellectual disability services), Ulvila
- 12.5. Satakunta Hospital District, Antinkartano rehabilitation centre (rehabilitation and research centre for intellectual disability services), care home Mänty (rehabilitation unit for individuals who have become disabled as adults), Ulvila
- 26.5. Carea – Kymenlaakso Social and Health Services, social service units Maununniitty and Kuntorinne, Kuusankoski
- 26.5. Carea – Kymenlaakso Social and Health Services, social service unit Tuulikello, Kuusankoski
  7.6. City of Helsinki, Mörssärinaukio group home* (housing services for people with intellectual disabilities and autism)
- 25.10. Savon Vammaisasuntosäätiö foundation (SAVAS), Louhumäki service home* (assisted living for people with intellectual disabilities and people with autism), Kuopio
- 25.10. Savon Vammaisasuntosäätiö foundation (SAVAS), Savolanniemi service home* (assisted living for people with intellectual disabilities and people with autism), Kuopio
- 17.11. Care home Esperi Hoivakoti* (private housing services for the elderly), Kerava
- 17.11. City of Kerava, Hopeahovi service centre * (housing services for the elderly)
- 1.12. Municipality of Loppi, Harjukoti* (institutional care for the elderly)
- 1.12. Municipality of Loppi, Salmela care home* (24-hour housing service for the elderly)
- 8.12. Kainuu Social Welfare and Health Care Joint Authority, Kuusanmäki Service Center, unit for special respite care (ward 22) and unit for institutional care (ward 24)

Health care

- 19.4. Pirkanmaa Hospital District, Vammala Hospital, acute psychiatric ward 3
- 19.4. City of Tampere, Hatanpää Hospital, psychogeriatric wards
- 19.4. First Aid Unit Acuta at Tampere University Hospital (Tays)
- 20.4. Tays Pitkäniemi Hospital, neuropsychiatry and geriatric psychiatry wards 1, 3 and 4 and operative outpatient clinic, Nokia
- 21.4. Espoo city, Sobering-up station at the Kilo police station*
- 21.4. Turku University Hospital (Tyks), Turku Region Joint Emergency Services, isolation facilities*
- 22.4. Health care services for prisoners, outpatient clinic in Turku
- 23.11. South Karelia Central Hospital, psychiatric wards PS 1 (closed mental health and substance abuse ward) and PS 3 (closed mental health ward)*
- 8.12. Health care services for prisoners, outpatient clinic in Kylmäkoski